

Integrative & Functional Medicine Patient Informed Consent Form

Patient Name: _____ Date: _____

The informed consent form relates to integrative and functional medicine treatment provided by Dr. X at the Clinic. The purpose of this informed consent form is to provide you with a written version of the information Dr. X will discuss with you regarding the risks, benefits and alternatives of integrative and functional medicine, and to document your consent to this treatment. This document serves as a supplement to the discussion you will have with Dr. X. It is important that you fully understand this information, so please read this document thoroughly. Please initial every paragraph of this form that has the words "Patient Initial__" to confirm that you have read and understood that paragraph. If you do not understand or accept any paragraph or part of this form, please advise Dr. X and do not place your initials on this form. If you have any questions regarding the treatment, ask Dr. X prior to signing the consent form. You may withdraw consent at any time by telling the doctor performing the treatment.

Please ensure you REVIEW and INITIAL the following statements to ensure you understand the nature of the treatment provided by Dr X

Integrative & Functional Medicine

I understand that Dr X practices integrative and functional medicine. This means that he/she uses conventional medicine, functional medicine and complementary and alternative medicine (CAM) to treat illness and optimize health. The approaches to care, diagnoses, investigations, treatments, or other care practices or services that fall within integrative and functional medicine are considered "unconventional" by current medical standards and may not necessarily be well accepted or understood by conventional medical doctors. Additionally, such care practices are not often considered as "medically necessary" and are therefore considered to be optional services to be used as an adjunct to conventional care. By initialing below, I acknowledge that I understand that integrative and functional medicine are not considered medically necessary and that I consent to receiving health care pertaining to integrative and functional medicine.

Patient Initial: _____

Consultation Services

I understand that integrative and functional medicine is personalized care that provides individualized therapies that are complementary to the conventional treatment a patient receives. An integrative and functional medicine consultation may include, but is not limited to, the following: 1) medical assessment of a person's condition including history and physical exam where applicable; 2) communication of any relevant diagnoses and any inter-relatedness between multiple diagnoses; 3) recommendations for relevant lab testing of

blood, urine, stool, hair, skin, or breath which may or may not be covered by OHIP; 3) individualized recommendations pertaining to lifestyle, nutrition, supplements, vitamins, natural products, herbal products, prescription medications, other therapies, referrals to medical specialists or other health care providers.

Patient Initial: _____

Care Model

I understand that Dr X provides integrative and functional medicine as a consultant physician. He/she does not practice primary care, does not accept patients as a family physician or primary care provider, and does not take over for care provided by a patient's regular family doctor or specialists. Patients must keep their regular family doctor for routine or episodic medical care, cancer screening, etc., and are advised to continue care with their conventional medical specialists for ongoing management of conditions requiring specialist care. By initialling below, I acknowledge and understand that Dr. X is not my primary care provider, does not provide family medicine, and provides her services as an optional consultant to complement my conventional medical care.

Patient Initial: _____

Clinical Outcomes

I understand that Dr. X offers integrative medical therapies and applies the principles of functional medicine to examine the root causes of illness. I understand that Dr. X cannot make any guarantees that this medical care will yield desired clinical effects or nor can he/she predict a timeline for such effects. I am aware that I have the right to choose to receive any services recommended by Dr. X and may refuse any or all treatment suggestions at any time. By initialling below, I accept that health benefits cannot be guaranteed and exacerbations of symptoms are possible.

Patient Initial: _____

Virtual Care

I understand that Dr. X's visits are primarily conducted virtually via an encrypted and PHIPA-compliant electronic medical record videoconferencing system, Y. Telephone consultations can be used as an alternative. In-person visits may be requested by Dr. X when a physical exam is required to complete a patient assessment or may also be available by special request depending on clinic room availability. In order to provide virtual care, patients must be located in a reasonably private environment, safe from risk of physical harm (i.e. services are not to be provided while driving) and located within Ontario at the time they receive care. By initialling below, I consent to receiving virtual care when it is safe and appropriate.

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Electronic Communication

I understand that Dr. X and the Clinic would like to communicate with patients by whatever means are most convenient and appropriate for effective patient care. This could be via

email, videoconference, telephone, or leaving voicemail messages. Some of these means of communication may not be considered secure or could be reviewed by other persons (i.e. other household members). By initialling below, I consent to the Clinic communicating with me by whatever means are deemed most appropriate based on my preferences and the nature of the information to be shared. I will inform the Clinic if I have specific communication preferences, or do NOT consent to receive communications in one or more of the above manners so that alternate means of communication for the planning and delivery of my health care. I acknowledge that the Clinic will communicate with me only in accordance with my communication preferences, which I can change at any time.

Patient Initial: _____

Tests and Assessments

I understand that Dr. X will occasionally recommend tests and assessments that are not generally considered to be within the definition of conventional medicine and/or are not covered by OHIP. These investigations are not mandatory for the provision of care but may be recommended if they may assist with assessments and decision making. Auxiliary lab tests are ordered through the Ontario-based laboratory broker, In Common Labs (<https://iclabs.ca/>), which directs samples to appropriate testing centres, many of which are located in the USA or internationally. ICL is licensed by the Ontario Ministry of Health and is accredited by Accreditation Canada Diagnostics. ICL's referral laboratories are also licensed and accredited. We cannot guarantee that Canadian privacy laws regarding personal information will necessarily be applied with the ordering or submission of test samples that leave Canada for processing. It is possible that only local laws pertaining to the privacy of information may be applied when samples are located out of the country (i.e. USA privacy laws will apply to samples when they are located within the USA). The Clinic charges a fee of 10% of the actual test cost to cover the administrative costs of ordering, receiving and managing unmedically necessary tests. No profits are made by Dr X or by the Clinic when tests are recommended or ordered. By initialling below, I acknowledge that certain tests or assessments recommended are optional unmedically necessary investigations that are not covered by OHIP. I further acknowledge that the testing centres may not conform to Canadian privacy laws entailed within PHIP

Patient Initial: _____

Conflict of Interest

I understand that Dr. X obtains no financial profit from any of the therapeutic recommendations he/she provides, including but not limited to:

- Supplement products
- Laboratories selling health care products
- Laboratory testing
- Access to other health care practitioners

Dr. X only recommends supplement brands that are certified in Canada, have high manufacturing quality standards, and are third-party tested or certified for quality. The

Clinic sells certain supplements and health care products which have been approved by Health Canada, however, I am not obliged to purchase products at the clinic and may obtain natural products elsewhere including but not limited to other natural product stores or online.

Patient Initial: _____

Cost of Services

Integrative & functional medicine services are offered at a rate of **\$Z/hour**.

The above rates are posted at the Clinic. Patients will be charged based on actual time spent in the encounter rather than as booked. Patients will be given the full allotted visit time even if the visit begins late. Fees may be subject to change at anytime without notice.

Cancellation Policy

I acknowledge that the Clinic has a 24-hour cancellation policy. Patients are required to provide at least 24 hours' notice for cancellation of any appointment. Failure to provide 24 hours' notice or failure to attend appointment will result in a \$75 fee.

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Insured vs Uninsured Services

The College of Physicians and Surgeons of Ontario's (CPSO) CAM policy requires physicians practising integrative & functional medicine to perform conventional medical assessments and provide conventional medical diagnoses prior to providing any treatment that may be considered CAM. This portion of your visit (assessment) is therefore covered by OHIP. You will be required to provide your OHIP card to cover the portion of your visit which is insured.

I understand that integrative and functional medicine treatments do not fall within the scope of conventional medicine and are generally deemed "not medically necessary." These treatments are typically not covered by OHIP. The above fees pertain to the portion of my visit which is uninsured, i.e. integrative and functional medicine treatment recommendations, counselling, advice, discussing & ordering advanced tests and investigations. I acknowledge that I will be required to pay privately for integrative and functional medicine treatment and any other services that are not considered medically necessary and/or are otherwise not covered by OHIP, and that I can refuse any treatment at any time.

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Alternatives

Integrative and functional medicine are optional services to be used as an adjunct to conventional medical care. You are not required to participate in this form of care. Alternatives include follow-up with your family doctor or conventional medical specialists

(covered by OHIP), naturopaths (may be covered by private insurance), integrative & functional medicine nurse practitioners (private pay), or other health care providers.

Please contact the clinic if you have any questions about insured vs uninsured services or if you are interested in integrative & functional medicine services but are concerned about affordability. By initialling below, you acknowledge that integrative & functional medicine services are not covered by OHIP and accept the hourly rates outlined above for this treatment.

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Access to Personal Health Information (PHI)

In order to provide informed care, Dr. X may be required to access a patient's personal health information. Dr. X will only collect, use, disclose, or access a patient's personal health information in accordance with the Ontario *Personal Health Information and Protection Act, 2004*, and only with their express consent.

Referrals

Referrals from community physicians, specialists and allied health providers are accepted but are not required for booking an initial visit with Dr. X.

Communication with Family Physicians and Family Health Organizations (FHOs)

The Clinic would like to inform family physicians about initial consultation bookings. Family physicians who belong to a FHO benefit from open communication about patient visits with external physicians, as this allows them to make arrangements for rostered patients to be seen by other physicians without penalizing the FHO. No medical information will be shared in this communication, the purpose is simply to advise the physician of the booking. I consent to the Clinic informing my family physician about my initial booking with Dr. X.

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Questions or concerns?

Please direct any questions or concerns about this consent form to our clinic reception staff and we will do our best to accommodate your needs in order to provide care.

Statement of Consent

By signing this form, you confirm that you hereby voluntarily consent to integrative and functional medicine provided by Dr. X. The treatment has been fully explained to you including risks and potential side effects. You have had the opportunity to ask any questions you may have and those questions have been answered to your satisfaction. You accept the risks and complications of the treatment and you understand that no guarantees are implied as to the outcome of the treatment. If you have any post-treatment questions or concerns, or changes in your medical history, you will notify Dr. X or your family physician.

Patient Name: _____ Patient Signature: _____
Date: _____

References:

College of Physicians & Surgeons of Ontario Complementary and Alternative Medicine Policy
(Complementary and Alternative Medicine (CAM) encompasses the practice of integrative and functional medicine). <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Complementary-Alternative-Medicine>.

CPSO Uninsured Services: Billing & Block Fees Policy <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Uninsured-Services-Billing-and-Block-Fees>

OMA Guide to Uninsured Services (includes estimation of hourly rate and fees for non-OHIP services)
[https://swpca.ca/Uploads/ContentDocuments/2019-Physicians-Guide-to-Uninsured-Services-10Jan19%20\(004\).pdf](https://swpca.ca/Uploads/ContentDocuments/2019-Physicians-Guide-to-Uninsured-Services-10Jan19%20(004).pdf)