SUNMI Naturopathic Health
Healing through Nature

New patient intake form-Adult

Dear New Patient,

Welcome to the Sunmi Naturopathic Health. You have just taken an important step towards optimizing your health.

Before your first visit, please complete an intake form and bring it all with you to your first appointment so that I can better understand your health history and health goals. Please complete the package as thoroughly as possible. If you have any questions regarding the form, leave the section blank and we will go over it at your appointment. All information is strictly confidential.

The first visit includes an in-depth naturopathic assessment of your health concerns, medical history, and health goals which will last anywhere from 1 to 1.5 hours. I will review your completed health questionnaire with you, ask detailed questions relevant to your health concerns, run a screening urine test and perform a physical exam if time permits. I may recommend certain diagnostic tests in order to gain a better understanding of your health status. In most cases, a second follow-up visit will be scheduled and may take up to 1 hour to complete. This visit will be used to complete the physical exam, to discuss the results of your test(s) and to implement a treatment plan. Your treatment plan may include any combination of dietary recommendations, lifestyle changes, herbs, Chinese medicine, acupuncture, or nutritional supplements. Subsequent visits will be booked, as necessary, to review your progress and make appropriate changes to your program. Follow-up visits can be scheduled anywhere from 30 to 45 minutes.

It is essential to remember that you need to be patient with your body.
Some of our patients have spent many years with chronic medical problems unsolved by conventional medicine. Some are currently receiving positive and necessary treatment from one or more medical doctors or other health-care providers. Some are simply not feeling well and want to improve their general health. Whichever scenario applies to you, it is important to realize that it takes time to feel better when using naturopathic medicine. We usually tell patients to expect to visit us at least four (4) times and to expect to wait approximately two (2) months before noticing significant changes. Some patients of notice changes much sooner, but as a patient, we ask you to be patient! We are confident that with the necessary information and a consistent effort from you, we can help you; but it may take some time.

Any supplements prescribed at your visits can be purchased from the clinic, a health food store or a medical supply company of your choice.

Please note that payment is due at the end of your visit. Be sure to check with your extended health care plan to determine if the appointment cost will be covered. If you are unable to make a scheduled appointment, please provide at least 24 hours notice, so that time can be made available to another patient. Missed appointments without notice will be subject to a charge of the full fee.

Parking: Free parking is available. Driveway is located right off St.Laurent Blvd.

If at any time you have questions or concerns regarding your treatment, please feel free to voice them during your visits, or contact me at the office at 613.501.4312. I look forward to working with you to help you enjoy long lasting improvements in your health.

Best in health,

Dr. Sunmi Cha, BScH, ND
Naturopathic Doctor

SUNMI CHA, ND
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Professional Fees for Naturopathic Services

The following fee scale is based on the consultation, as well as the time needed to research and design an individualized treatment plan for you.

ADULT

In-office consults Fees

Type of Visit	Length	Fees
Initial Consult - Adult Thorough health history taken Urinalysis Physical exam Lab tests, if required (extra cost)	60 minutes	$200
2nd Visit - Adult General screening physical exam Initiation of treatment plan Nutritional consultation	30 minutes	$100
Follow up Visit Monitoring of treatment plan	15 minutes	$65
	30 minutes	$100
	60 minutes	$200
Acupuncture / Cupping Must follow an initial consultation	45 minutes	$100
Acute Visit (colds/flus)	15 minutes	$65
B12 Shot Only	5 minutes	$40
Phone/Skype consultations Must follow an initial consultation in person	15 minutes	$65
	30 minutes	$100

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PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO YOUR FIRST APPOINTMENT
(Please print clearly)

NATUROPATHIC INTAKE FORM

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Your time and thoughtfulness in completing this overview will aid with the assessment of your health needs.

Name: _____ Date: _____
Date of birth: _____ (M/D/Y) Age: _____ Gender M F Other_____
Address:_____ City: _____ Province: _____ Postal: _____
E-mail Address:_____ Occupation:_____
Telephone number: Home:_____ Work:_____ Mobile:_____
Emergency contact: Name: _____ Phone: _____ Relation: _____
Marital Status: _____ Name of Spouse: _____ # Dependents: _____

Do you have health insurance with naturopathic medical coverage? ❑ Y ❑ N

How did you hear about Dr. Sunmi Cha, ND: Internet Search / Referral by Doctor
(specify who):_____ Other (please specify): _____

Other health care providers:

1. Name:_____
Profession:_____
Phone:_____
Fax:_____

2. Name:_____
Profession:_____
Phone:_____
Fax:_____

3. Name:_____
Profession:_____
Phone:_____
Fax:_____

Have you ever consulted a naturopathic doctor, an acupuncturist, a nutritionist or counselor before? (Please circle)

HEALTH INFORMATION

Major Symptoms: Please list in order of importance what symptoms are of concern to you.

Please list most concerning to least, along with the approximate date of onset:	Date of onset
1.	
2.	
3.	
4.	
5.	

Height: _____ Current weight: _____ Weight 1 year ago: _____ Max weight: Year: _____
How would you describe your general state of health?
Excellent Good Fair Poor
How stressful is your work, or other aspects of your life? Rate your stress level (10 = high)
1 2 3 4 5 6 7 8 9 10
The main stressor is:
❑ Financial ❑Job related ❑ Marriage ❑ Health ❑ Interpersonal ❑ Unfulfilled expectations ❑ Family ❑Other:
Please list your most stressful life experiences (physical or psychological):
1. _____ Age: _____

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2. _____ Age: _____
3. _____ Age: _____

How well do you handle these stresses?

_____

_____

SUPPLEMENTS/DRUG MEDICATIONS

Please list all current vitamins/minerals, herbs, or homeopathic remedies, along with the daily dose, how long you have taken it and the reason for the supplement.

Supplement	Dose/ day	How long?	Reason for supplement
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please list all current medications (prescription and over-the-counter), the daily dose, how long you have taken it, and the reason for the prescription.

Medication	Dose/ day	How long?	Reason for medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please list any adverse reactions or side effects that you have experienced and which supplement/medication you suspect to be the cause:

_____

_____

In the last 10 years, how many times have you been treated with antibiotics? _____

MEDICAL HISTORY

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "Self" if it relates to you and/or Father (F), mother (M), sibling (S), Grandparent (G), your child (C). Please circle Past if the condition is resolved, or Current if it is ongoing and current.

	Yes (v)	Relation Please circle	Dates Resolved		Yes (v)	Relation Please circle	Dates Resolved
Alcoholism/ drug addiction		Self F M S G C	Past/Current	High blood pressure		Self F M S G C	Past/Current

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Allergies		Self F M S G C	Past/Current	Low blood pressure		Self F M S G C	Past/Current
Heart disease		Self F M S G C		High cholesterol		Self F M S G C	Past/Current
Anemia		Self F M S G C	Past/Current	Hepatitis		Self F M S G C	Past/Current
Arthritis		Self F M S G C	Past/Current	Headaches		Self F M S G C	Past/Current
Asthma		Self F M S G C	Past/Current	Kidney disease		Self F M S G C	Past/Current
Bladder/urinary dz		Self F M S G C	Past/Current	Skin problems		Self F M S G C	Past/Current
Cancer		Self F M S G C	Past/Current	Stroke		Self F M S G C	Past/Current
Diabetes		Self F M S G C	Past/Current	Tuberculosis		Self F M S G C	Past/Current
Depression/ other mental illness		Self F M S G C	Past/Current	Thyroid disease		Self F M S G C	Past/Current
Eczema		Self F M S G C	Past/Current	Osteoporosis		Self F M S G C	Past/Current
Epilepsy		Self F M S G C	Past/Current	Others:		Self F M S G C	Past/Current
Lung disease		Self F M S G C	Past/Current			Self F M S G C	Past/Current

Please list any past surgeries or hospitalizations with the approximate dates: along with approximate dates.

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____

Please list all past injuries (ie. Broken bones, joint sprains, burns, falls, car accidents etc.): along with approximate dates.

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____

Please list all allergies (food, medication, environmental):

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please indicate what immunizations you have had

¨DPT (diphtheria, pertussis, tetanus) ¨Haemophilus influenza B ¨Hepatitis A
¨Tetanus booster; when? _____ ¨Flu ¨Hepatitis B
¨MMR (measles, mumps, rubella) ¨Polio ¨Smallpox
Other _____
Please indicate if any caused adverse reactions: _____
Do you get regular SCREENING TEST done by another doctor? (Pap, blood tests, etc.)? ¨Y ¨N
Date of last physical exam:_____ For what reason?_____

WOMEN ONLY

Reproductive History

If you are female are you currently pregnant? Yes No Unsure (Please circle one) Due date_____
Age at 1st menstrual period _____ First day of most recent menstrual period _____
Usual Flow: Heavy _____ Moderate _____ Light _____ Length of period in days _____
Number of days between periods _____ Clots in menstrual flow _____ Colour of flow _____
Do you have: Painful periods /missed periods /spotting between periods /vaginal bleeding /unusual discharge or

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infection /recurring vaginal infections
If you have gone through menopause, have you had any postmenopausal bleeding? _____
Date of last Pap _____ History of abnormal Pap? _____
Number of: Pregnancies _____ Live Births ____ Abortions _____ Miscarriages _____
Have you experienced complications during pregnancy/delivery/other problems? ¨Y ¨N

_____

Contraceptive History

What type of contraception are you taking? _____
Problems with the current method? _____
Sexual preference: heterosexual ____ homosexual ____ bisexual ____

MEN ONLY

Do you have: Bothersome urinary symptoms _____ Erectile dysfunction _____ Premature ejaculation _____ Difficulty with orgasm_____ Prostate problems _____ Pain or swelling of the testicles _____ Feeling of coldness or numbness in genitalia _____Vasectomy _____ Other sexual dysfunction _____
Have you sought Medical intervention for these problems? If so, when?_____

_____

CONTEXT OF CARE REVIEW

What three (3) expectations do you have from this visit?

1. _____
2. _____
3. _____

What long-term expectations do you have of your naturopathic doctor?

_____

_____

What behaviours/habits do you currently engage in regularly that you believe support your health? (Please list)

_____

_____

What are the potential challenges that might prevent you from achieving your health goals?

_____

_____

Who is/are your biggest support(s)?

_____

What do you LOVE to do? What are your interests and hobbies?

_____

_____

How would you describe the emotional climate of your home? Do you have a supportive family or friends who are there when you need them?

_____

_____

LIFESTYLE

	Quantity/day
Drink alcohol ❑Y ❑N	
Drink Coffee ❑Y ❑N	

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Do you smoke? ❑Y ❑N	
Recreational drug use ❑Y ❑N	
Dietary restrictions ❑Y ❑N	Vegan❑ Vegetarian❑ Other_____
What do you eat on a "typical" day?	
Breakfast	
Lunch	
Dinner	
Snacks	
Foods you tend to crave	
Foods you dislike	

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

How many hours of sleep do you usually get per night during the week? _____

Do you awake feeling rested? Y / N Do you feel you sleep well at night? Y / N

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____

_____

Please list any additional information you believe is important for us to address during your visits:

_____

_____

_____

_____

_____

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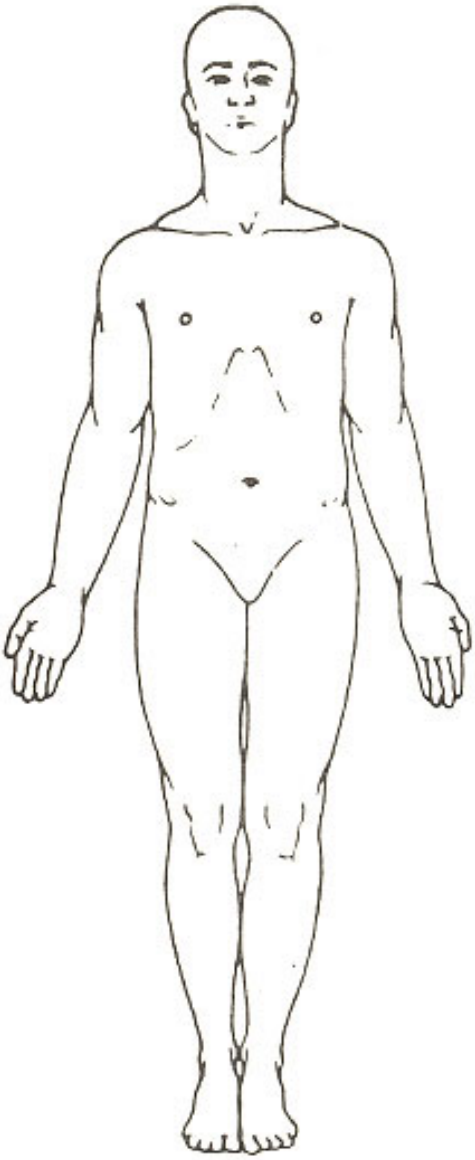
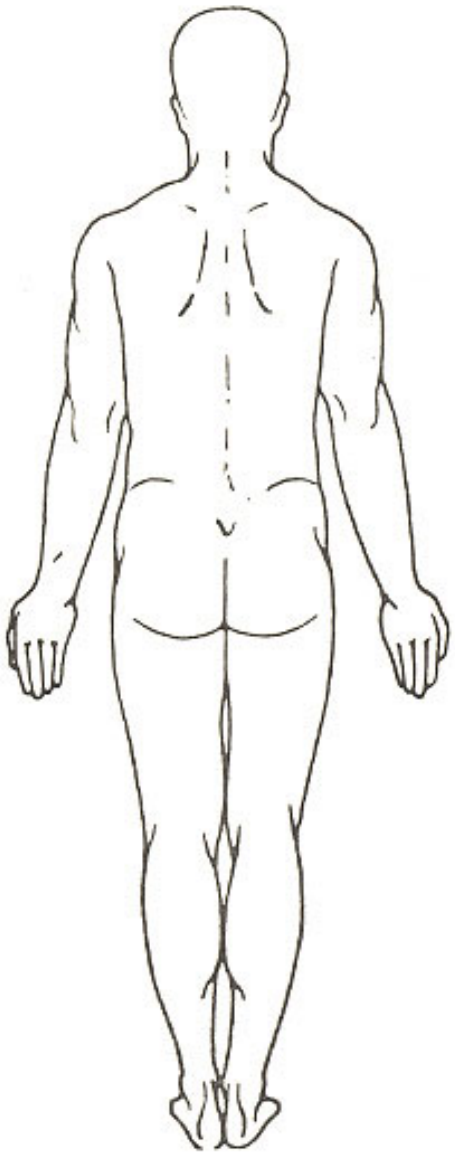
Pain Questionnaire - Part One

Where Is Your Pain?

Please mark, on the drawings below, the areas where you feel pain. Put **E** if external, or **I** if internal, near the areas, which you mark. Put **EI** if both external and internal.





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Part Two - What Does Your Pain Feel Like?

Some of the words below describe you *present* pain. Check **ONLY** those words that best describe it.

❑ Throbbing ❑ Shooting ❑Stabbing ❑Sharp ❑Gnawing ❑Tugging ❑ Burning ❑ Tingling
❑ Dull ❑ Tender ❑ Itchy ❑ Aching ❑ Radiating ❑ Numb ❑ Cold ❑ Unbearable

Part Three – How Does Your Pain Change With Time?

1. Which word or words would you use to describe the **pattern** of your pain?

❑Continuous ❑Intermittent ❑ Brief

2. What kinds of thing(s) relieve your pain?

_____
_____
_____

3. What kinds of thing(s) increase your pain?

_____
_____
_____

4. Please rate how your injury has affected your day-to-day function by placing a check mark in the appropriate spaces.

Pain	❑ Severe	❑ In Bed: Severe	❑ Non-Active	❑ None
Physical mobility	❑ Severe	❑ In Bed: Severe	❑ Non-Active	❑ None
Stiffness	❑ Severe	❑ In Bed: Severe	❑ Non-Active	❑ None
Social interaction	❑ Severe	❑ In Bed: Severe	❑ Non-Active	❑ None
Concentration	❑ Severe	❑ In Bed: Severe	❑ Non-Active	❑ None

Thank you for taking your time to complete this intake form,
all information gathered here will contribute to the success of your naturopathic care.

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Review of system & TCM Questionnaire

P	Past
C	Current
S	Significant symptom/concern

You can leave the column empty if the symptom is not apply to you.

P	C	S	Condition
GENERAL			
			Fatigue
			Insomnia
			Generally cold
			Generally hot
			Flushed sensation
			Aversion to wind / draft
			Weight gain: Unintentional
			Weight loss: Unintentional
			Generalized body aches
			Heavy sensation in the body
			Other
SKIN & HAIR			
			Rashes
			Hives
			Itching
			Eczema
			Psoriasis
			Pimples/Acne
			Skin cancer
			Tumors, lumps
			Edema/ swelling
			Jaundice
			Color/Size changes in moles
			Color changes, ridges, pits, white spots on nails
			Loss of hair
			Dry scalp/Dandruff
			Premature greying of hair
			Fungal infections
			Other:
HEAD & NECK			
			Dizziness
			Fainting
			Neck pain / stiffness
			Lumps/swellings glands in head/neck
			Headaches / migraines
			Head injury / Concussions
			Jaw pain/TMJ syndrome
			Other
EARS			
			Ear infections
			Ringing (Tinnitus)
			Difficulty hearing
			Dizziness/vertigo
			Pain in ears
			Other
EYES			
			Visual changes
			Poor eyesight/difficulty seeing
			Glasses/Contacts
			Sensitivity to light / sun
			Poor night vision
			Blurred / double vision
			Spots / floaters
			Cataracts
			Glaucoma
			Blind spot
			Eye infection / inflammation
			Dry eyes
			Other
NOSE, THROAT, MOUTH			
			Nose bleeds (Epistaxis)
			Sinus congestion/infections
			Hay fever or allergies
			Dry nose
			Loss of smell
			Dry mouth
			Teeth grinding
			Cavities/Fillings
			Root canals
			Mouth cankers / sores / ulcers
			Bleeding gums/gingivitis
			Loss of taste
			Bitter taste / Stickiness in the mouth
			Dry throat
			Frequent sore throats
			Strep throat
			Persistent hoarseness
			Difficulty swallowing
			Feeling of lump in throat
			Feeling of tight ness or congestion of the throat
			Swollen tonsils
			TMJ problem
			Other
CARDIOVASCULAR			
			High Blood pressure
			Low blood pressure
			Heart disease
			Blood clots
			Palpitations
			Irregular heart beat
			Chest pain
			Cold hands & or feet / Raynaud's
			Swelling / Fluid retention
			Deep leg pain / Leg cramp
			Varicose veins / Spider veins
			Skin ulcers on extremities
			Slow wound healing
			Excessive bleeding
			Unusual/easy bleeding
			Easy bruising
			Rheumatic fever
			Other
RESPIRATORY			
			Frequent colds
			Asthma
			Bronchitis
			Chronic Obstructive Pulmonary disease (COPD)
			Pneumonia
			Respiratory tract infections
			Coughing blood
			Shortness of breath
			Pain on breathing
			Wheezing
			Chest congestion
			Coughing up blood
			Night sweats
			Other
GASTRO-INTESTINAL			
			Nausea
			Vomiting
			Vomiting blood
			Excessive gas or belching
			Heart burn or acid reflux
			Bad breath
			Abdominal pain or cramps
			Rumbling &/ Gurgling sensation in the intestine
			Indigestion
			Eating disorder (Anorexia / Bulimia)
			Compulsive / Binge eating
			Poor appetite
			Excessive appetite
			Strong thirst
			Lack of thirst
			Liver disease
			Gall bladder disorder
			Hemorrhoids
			Rectal pain
			Rectal prolapse
			Diarrhea

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			Constipation
			Alternating constipation/diarrhea
			Irregular bowel movement
			Loose stools
			Undigested food in stool
			Blood in stools/ black stools
			Foul smelling stool
			Strain during bowel movement
			Constantly needing to pass stools (Tenesmus)
			Other

GENITO-URINARY

P	C	S	Condition
			Kidney stones
			Pain during urination
			Increased frequency of urination
			Increased urination at night
			Urgency / Hesitancy to urinate
			Unable to hold urine
			Difficulty starting or maintaining urine flow
			Weak urinary stream
			Involuntary urination, especially at night (Enuresis)
			Blood in urine
			Other

MALE

P	C	S	Condition
			Pain/ itching genitalia
			Genital lesions/ discharge
			Impotence
			Erectile dysfunction
			Lumps in testicles
			Infertility
			Other

Women

P	C	S	Condition
			Frequent urinary track infections
			Frequent vaginal infections
			Pain / itching of genitalia
			Genital lesions
			Vaginal discharge
			Pelvic inflammatory disease
			Endometriosis
			Fibroids
			Abnormal pap smear
			Amenorrhea (no menses)
			Irregular menstrual periods
			Premenstrual pain or discomfort
			Premenstrual breast tenderness
			Abnormal bleeding / Spotting
			Pain with sexual intercourse
			Periods with heavy bleeding
			Dark colored menses
			Blood clots in menses
			Prolapse of uterus
			Breast lumps
			Menopausal syndrome
			Hot flashes
			Infertility
			Miscarriages
			Facial hair (women)
			Other

NEUROLOGICAL

P	C	S	Condition
			Seizures / Convulsions
			Tremors
			Paralysis
			Perspiration deficient
			Perspiration excessive
			Loss of balance/fainting
			Facial twitching
			Drooping eyelid(s)
			Blackouts
			Tremors (shaking, trembling)
			Other

PSYCHOLOGICAL

P	C	S	Condition
			Depression
			Anxiety / nervousness
			Treated for emotional or Psychological problems
			Stress
			Anger
			Frustration
			Irritability
			Agitation / restlessness
			Indecisiveness
			Lack of courage / Shy/ Timid
			Lack of initiative
			Overthinking / Constant worry
			Sighing
			Suicidal thoughts
			Attempted suicide
			Unable to express emotions
			Self-critical
			Critical of others
			Fearful/Phobic
			Loneliness
			Lack of confidence
			Mood swings
			Recreational drug use
			Prefers to be with people
			Likes to be alone
			Organized and very neat
			Confident and secure
			Often feel sad
			Easily startled
			Delirium
			Difficulty concentrating
			Foggy headedness
			Forgetfulness &/or poor concentration
			Poor memory
			Mental confusion
			Mental exhaustion (lassitude)
			Muttering to oneself
			Tendency to hit or scold people
			Uncontrolled laughter, crying, shouting
			Vivid dream
			Decreased libido
			Increased libido
			Other

INFECTION SCREENING

P	C	S	Condition
			HIV
			TB
			Hepatitis
			Gonorrhea
			Chlamydia
			Syphilis
			Genital warts
			Herpes: oral
			Herpes: genital
			Other

MUSCULAR-SKELETAL

P	C	S	Condition
			Arthritis
			Joint pain/stiffness
			Joint swelling
			Muscle spasm, twitching, cramps
			Back pain: Upper / middle
			Low back pain
			Sciatica
			Numbness or weakness
			Sore, cold or weak knees
			Burning of soles of feet
			Slow physical development
			Other

Thank you for taking your time to complete this intake form

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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive treatments are generally used to stimulate the body's healing capacity. As part of your naturopathic treatment, a thorough case history, physical examinations and certain diagnostic testing may be performed.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include dietary modification, clinical nutrition, lifestyle counseling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy and physical medicine.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends dramatically on the individual and the extent of the illness. Some therapies must be used with caution in certain conditions or disease such as diabetes and/or heart/liver/kidney disease; therefore, it is very important that you inform your naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

Some of the potential health risks that may arise with treatment by naturopathic medicine include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injures from spinal manipulation.
- The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

Herbal Dispensary & Naturopathic Medicines:

The naturopathic doctor may prescribe supplements that can be purchased from clinic or at other locations. I understand that I have a freedom to choose where I purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors. Most insurance companies do not cover supplements that are prescribed and dispensed by the naturopathic doctor.

SUNMI CHA, ND
NATUROPATHIC DOCTOR
1085 Foley, Ottawa, ON K1G 2R4
Email: sunmichand@gmail.com Tel1. (613) 501.4312 Fax. (613) 903-4945 www.sunmihealth.com

SUNMI Naturopathic Health
Healing through Nature

Confidentiality

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fees. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Cancelled and Missed Appointments

I acknowledge that I must give at least 24 hrs. cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, a full fee will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of Dr. Sunmi Cha.

In Case of Emergency

I understand that emergency medical services are not offered by Sunmi Cha, ND. In case of an emergency, I should dial 911, or proceed to the Emergency Department of the nearest hospital.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario; No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive from Sunmi Cha, ND and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, administrative fees as well as other applicable fees.

_____	_____
Patient Full Name (please print)	Naturopathic Doctor (ND License # 2839)
_____	_____
Signature of Patient or Guardian (if patient is under 18 yrs of age)	Date of Consent

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PRIVACY POLICY

The Privacy of your personal information is an important part of business practice with Sunmi Cha, while at the same time providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

- Only necessary information is collected about you;
- Only with your consent is your information shared with others outside the clinic;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Sunmi Cha, ND's privacy policy conforms to privacy legislation and standards of the Board of Directors of Drugless Therapy – Naturopathy.

Personal information is collected in order to:

- Assess your health concerns and provide appropriate health care
- Advise you of treatment options
- Establish and maintain contact with you
- Send you newsletters and other information mailings
- Remind you of upcoming appointments
- Communicate with other treating health-care providers
- Allow us to efficiently follow-up for treatment, care and billing
- Invoice for goods and services
- Process credit card payments
- Collect unpaid accounts
- Comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing below, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information as outlined above.

PATIENT CONSENT I have reviewed the above information that explains how Sunmi Cha, ND will use my personal information, and the steps that they are taking to protect my information. I agree that Sunmi Cha, ND can use and disclose personal information about _____ as set out above in the information Sunmi Cha's privacy policies. (Patient Name)

Please sign and return this form to your Naturopathic Doctor on your first visit

_____ _____

Signature Date

_____ _____

Witness Date

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Email Communication Consent Form

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner that I am exposing myself to certain risks. These risks include:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain emails that pass through their systems.
- It is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- If the patient's email requires or invites a response from the practitioner and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient is responsible for informing the practitioner of any types of information the patient does not want sent by email.

The practitioner will use reasonable means to protect the security and confidentiality of email information sent and received; however, because of the risks just outlined, the practitioner cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct by practitioner.

Although the practitioner will endeavor to read and respond promptly to an email from a patient, the practitioner cannot guarantee that any particular email will be read and responded to within any particular period of time. Accordingly, patients should not use email for medical emergencies or other time-sensitive matters. Email communication is not an appropriate substitute for clinical examinations.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by email between the practitioner and me. I consent to communicating by email with practitioner in spite of these risks.

Patient Name _____

Patient Email _____

Signature _____ Date _____

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ACKNOWLEDGEMENT

TO: Sunmi Cha ND

FROM: Your name _____

RE: **CONSENT TO TREATMENT**

Your name_____

I hereby acknowledge that my naturopathic doctor has explained to me the nature of the naturopathic treatment I am to receive including the benefits of the treatment, any risks associated with the treatment and any medical alternatives. I hereby consent to the treatment as set out below.

I may withdraw my consent to this treatment at any time.

DATE: _____

SIGNATURE: _____

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