



# PATIENT CONTACT INFORMATION AND CONSENT FORM

Please fill in the following information and return this form to the front desk when completed

Name \_\_\_\_\_ M  F  Today's Date (Day/Mo/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth (Day/Mo/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ Care Card Number \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Emergency Contact name \_\_\_\_\_ Relationship \_\_\_\_\_ Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Please send me information by email regarding upcoming talks, events, and special offers.

If the above is a child: Parent(s)/Guardian(s) names \_\_\_\_\_

Children's names and ages \_\_\_\_\_

### How did you hear about our clinic?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Super Pages (Langley/Surrey book)  | <input type="checkbox"/> BCNA                    | <input type="checkbox"/> Choices Market      |
| <input type="checkbox"/> Super Pages (Vancouver book)       | <input type="checkbox"/> Friend/colleague/family | <input type="checkbox"/> driving by our Sign |
| <input type="checkbox"/> Super Pages (White Rock/S. Surrey) | <input type="checkbox"/> Talk/Presentation       | <input type="checkbox"/> Chamber of Commerce |
| <input type="checkbox"/> Canpages (Phonebook)               | <input type="checkbox"/> Local business          | <input type="checkbox"/> ACAM Website        |
| <input type="checkbox"/> MWC Website                        | <input type="checkbox"/> Gift Certificate        | <input type="checkbox"/> Art Show            |
| <input type="checkbox"/> Organic Grocer                     | <input type="checkbox"/> WTSMed Website          |  |

Other: \_\_\_\_\_ Who can we thank: \_\_\_\_\_

## INFORMED CONSENT

Dear patient,

Thank you for choosing Mountainview Wellness Centre. Our clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and improve the quality of life and health through natural and curative means.

Our Naturopathic Physicians provide comprehensive services that include:

1. Thorough case history analysis (medical and family history)
2. General Physical Examination (gynecological or prostate/male exams only if indicated)
3. Specific Laboratory Testing (e.g., screening and comprehensive blood analysis, urinalysis, stool analysis, environment and/or food allergy testing, heavy metal analysis, adrenal gland stress test, body composition and toxicity testing, blood and saliva hormone testing, early cancer detection, etc.)
4. Bodywork (massage, trigger point therapy, Bowen therapy)
5. Modalities (therapeutic ultrasound, myopulse, TENS, interferential, local UV light and low energy laser treatments)
6. Chelation Therapy
7. Mesotherapy (for pain management & esthetics)
8. Naturopathic Soft Tissue and Joint Manipulation
9. Counseling
10. Botanical Medicine
11. Hydrotherapy
12. Prolotherapy
13. Neurotherapy
14. Clinical Nutrition
15. Acupuncture
16. Homeopathy
17. Hydrogen Peroxide therapy

Please turn over.



### **PAYMENT POLICY**

Payment is due in full at the end of your visit for any applicable visit fees, lab work, treatments, or medications. All services, lab tests, and medications are HST applicable. A **Menu of Services and Tests** is provided for your convenience.

### **RETURN POLICY**

Unopened and undamaged items purchased from the Mountainview Wellness Centre may be returned for a full refund or credit, with receipt, within 30 days of purchase. Refunds on prepaid treatment packages will void any discounts on completed treatments.

Exceptions: 1.) **Special Orders** are subject to a restocking fee. 2.) **Refrigerated and Compounded Items** are final sale items. 3.) **All Lab Tests** are final sale

### **STATEMENT OF ACKNOWLEDGEMENT**

Even the gentlest therapies have potential complications and hence the medical information I have provided is complete. The risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements; pain, fainting, bruising or injury from blood draw; and disc injuries from spinal manipulations.

**I have read, understood and accept the above.**

---

(Signature of Patient, Parent or Legal Guardian)

---

(Date)