the naturopathic care centre

***Please Read First***

***Dear New Acupuncture Patient,***

*Thank you for making an appointment with me to begin improving your health with acupuncture. I congratulate you on your decision to take steps toward improved well-being. I look forward to working together to correct any imbalances that are presently causing your health challenges.*

*I would appreciate your careful consideration in answering the questions in the attached forms. By completing these forms with as much information as possible it will improve the accuracy of your assessment and allow us to have a more effective consultation. This reduces the need for extended consultation time and this subsequently saves you money and improves the care that I can provide for you.*

***Please fill out forms to the best of your ability and bring completed forms with you to your initial acupuncture consultation. If there are any questions you don't know how to answer, please leave them blank and we will discuss it at your appointment.***

*Acupuncture is unique in its approach to health. I practice acupuncture in the style of Classical Chinese Acupuncture. This type of acupuncture looks at the body as a whole and treats it accordingly to relieve symptoms and promote health and wellness. As looking at the body as a whole takes time, our first visit may involve acupuncture or may be assessment only depending on the complexity of your case. Acupuncture will start either in our first or second visit together.*

***In addition to being a Registered Acupuncturist, I am also a Naturopathic Doctor. If you are interested in exploring acupuncture as part of your treatment, this can be done either through my work as a Naturopathic Doctor or as my work as an Acupuncturist. Acupuncture can qualify for insurance reimbursement through either naturopathic benefits or acupuncture benefits depending on your benefit plan. In order to maximize your coverage from your benefits, before filling out this package of forms please check your benefit plan to ensure you have coverage for Registered Acupuncture. If you do not have any Registered Acupuncture coverage or you have both types of coverage, we recommend you fill out the Naturopathic New Patient forms rather than these forms. If you have coverage for Registered Acupuncture without available Naturopathic coverage or are an existing naturopathic patient at our clinic, please fill out this package of forms.***

*Thank you for your time in advance, and I look forward to working with you to achieve your optimum health.*

***Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.***
***Naturopathic Doctor & Registered Acupuncturist***

**288 Wellington Street, Stratford, ON N5A 2L9 Telephone 519-271-2440**
**reception@carriemeszarosnd.ca**

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2017 Fee Schedule and Office Policies for Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.

** These services are not currently subsidized by OHIP. All naturopathic and acupuncture visits are exempt from HST.

## Registered Acupuncture Visits

| | |
|---|---|
| *Initial Acupuncture Consultation (non-naturopathic patient) (60 minutes) | $160 |
| *Second Acupuncture Visit (for non-naturopathic patient) (45 minutes) | $115 |
| Acupuncture Treatment (without consultation) | $ 65 |
| Acupuncture with Consultation (30 minutes) | $ 80 |
| Acupuncture with Consultation (45 minutes) | $110 |
| Acupuncture Re-Assessment (18 months after last appointment) | $130 |

***Patients that are currently naturopathic patients are exempt from the initial and second visit acupuncture assessments and will be booked instead for either a 30 or 45 minute acupuncture consultation for their first acupuncture visit.**

## Naturopathic Visits

| | |
|---|---|
| Initial Consultation, adult patient (60 minutes) | $160 |
| Initial Child Consultation, (child age 12 and under) (45-60 minutes) | $140 |
| Second Visit (45 minutes) | $115 |
| Extended Second Visit (60 minutes) | $135 |
| Naturopathic Consultation (30 minutes) | $ 80 |
| Naturopathic Consultation (45 minutes) | $110 |
| Naturopathic Consultation (60 minutes) | $135 |
| Naturopathic Review (less than 15 minutes) | $ 45 |
| Naturopathic Re-Assessment (18 months after last appointment) | $130 |
| Naturopathic Acupuncture Treatment (without consultation) | $ 65 |
| Naturopathic Acupuncture with Consultation (30 minutes) | $ 80 |
| Naturopathic Acupuncture with Consultation (45 minutes) | $110 |

## Services and Fees

| | |
|---|---|
| Cancelled Appointment - with less than 48 hours notice | $ 35 |
| Missed Appointment - without notice | $ 50 |
| Simple Doctor's Notes | $ 25 |
| Comprehensive Medical Forms and Reports | fee based on complexity |

Fees for health services and supplements are due when services are rendered and may be paid by cash, cheque, Visa, MasterCard or Debit. There is a $20.00 fee for NSF cheques.

**We request a minimum of 48 hours notice in the event you cannot keep your appointment. Our answering machine is available during off hours to take any messages. With less than 48 hours notice we will charge $35 for cancelling without providing the adequate notice needed to allow us to fill the appointment space. If your appointment is missed without a cancellation call you will be charged $50. Please note that if you arrive late for your appointment, only the balance of time that had been booked for you can be used and you will be charged for the full visit length.**

For the respect and convenience of our patients and for efficient operation of our clinic, we endeavour to keep scheduled appointments on time. However, complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding.

Clarification emails or short phone calls (5 minutes or less) about existing treatment plans or to update us about significant health changes are encouraged without an associated fee. This would include clarifying instructions, reporting any new side effects associated with current treatment plans or any changes in prescription medications. Telephone consultations and emails that require lengthy responses are professional services and may be subject to a fee. Telephone calls of more than 10 minutes with our Acupuncturist will be billed as consultations.

I have read and fully understood the above description of this fee schedule and office policies and I agree to honour it.

Patient's or guardian's signature _____ Dated _____

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Dr. Carrie Meszaros, N.D., R.Ac.

Acupuncture Patient Intake Form

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Occupation: _____ Home /Cell Phone: _____

City: _____ Weight: _____ Work Phone: _____

Postal Code: _____ Height: _____ Email: _____

Emergency contact: _____ Relationship: _____ Phone number: _____

Doctor: _____ Clinic: _____ Phone number: _____

How would you like appointment reminders (circle one)? Phone Email

How did you hear about our clinic? _____ Do you want our e-newsletters (maximum of 3-4/year)? Yes No

What is your main concern? _____

What are your other concerns? _____

What seems to make you better? _____

What seems to make you worse? _____

Do you have any relevant or serious health conditions? _____

List any medications you are taking currently _____

**List any allergies or sensitivities you have and the symptoms they cause**:

Foods: _____

Drugs: _____

Environmental: _____

**How many hours of sleep do you get**? _____ Is it good quality? _____

**Do you have any issues with** falling asleep, waking through the night, restlessness, waking too early or trouble waking up in the morning (circle any that apply)?

**What is your energy level (1-10):** _____ When is your energy best? _____ When is it worst? _____

**What is your stress level (1-10)**: _____ What do you do to relax? _____

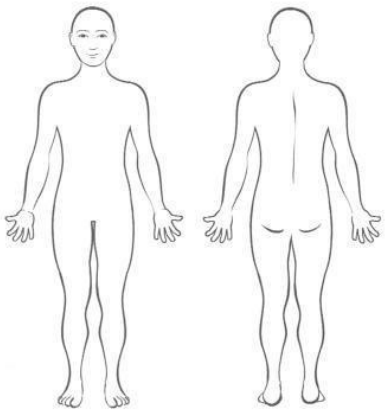
**Do you have any issues with** depression, anxiety, panic, irritability, anger, fear or other mood issues (circle any that apply)?

**How frequent are your bowel movements?** _____ (indicate per day or per week)

**Do you have any issues with** diarrhea, loose stools, constipation, straining or difficult bowel movements, gas, bloating, mucus in stool, blood in stool, or undigested food in your stool ? (circle any that apply)

**Do you have any issues with** heartburn, reflux, excessive belching or vomiting? (circle any that apply)

**Do you have pain?** Where, how intense (scale of 0-10), type of pain (mark on diagrams)? Provide additional information to the right of the diagrams, if desired.



Right side Right side

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History of major injuries/accidents/trauma/surgeries? Please describe:

Do you have headaches?: If yes please describe frequency, intensity and location:

**Family History** (please circle all conditions that have affected you or members of your family)

| | | | |
|---|---|---|---|
| Heart Disease | Diabetes | Stroke | Heart Attack |
| High Blood Pressure | Eczema | Allergies | Asthma |
| Inflammatory Bowel | Celiac | Other: | |
| Cancer (what type?) | | | |

**Have any of the following affected your health (currently or in the past)**

| | | |
|---|---|---|
| HIV/AIDS | Fainting | Cancer |
| Bleeding disorders | Pacemaker | Stroke |
| Are taking blood thinners | Hepatitis | Heart Attack |
| | | |
| Ringing in the ears | Dry skin | Acne |
| Premature grey hair | Dry hair | Eczema |
| Dry throat/mouth | Hair loss | Psoriasis |
| Night sweats | Heart palpitations | Low libido |
| Hot flushes | Vaginal dryness | Excessive sweating |
| Sensitivity to heat | Sensitivity to cold | Anemia |
| Numbness/tingling | Muscle cramps | Low blood sugar |

Any other information or concerns?

Women Only

Are you currently pregnant? Yes No If so, what is your due date: How far along are you?

Are you currently trying to conceive? Yes No If so, how long have you been trying:

applicable, please indicate how many (#) of pregnancies # of live births # of miscarriages

Do you have periods? How long is your cycle (i.e. 28 days) How long is your flow?

Do you have any of the following issues associated with your period (circle all that apply): heavy flow, light flow, clots, spotting, PMS, pain, sore breasts, fibroids, endometriosis, fertility issues, bloating, ovulatory pain?

**Consent to Collect and Release Information for The Naturopathic Care Centre**

I, or my appointed representative, consent for The Naturopathic Care Centre to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations **in the event of an emergency or with my permission.**

In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

**How Your Information Will Be Used**

Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist third party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

**Patient Access to Information**

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

**Acknowledgment**

- I allow for medical personnel to use and disclose my information as outlined above.
- I understand that I can access my personal health information except as outlined above.
- I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used or disclosed if mandated by law.

Additional Comments or Restrictions:

_____

Patient or Parent/GuardianSignature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____

**Dr. Carrie Meszaros N.D., R.Ac. 288 Wellington Street, Stratford ON, N5A 2L9 (519) 271-2440**

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**Patient Informed Consent to Treatment for Acupuncture at The Naturopathic Care Centre**

I, or the person listed below, have discussed with Dr. Carrie Meszaros N.D., R.Ac., the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles or moxibustion. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.

2. Acupuncture is very safe but rarely can cause slight pain, light-headedness, headaches, nausea, soreness, bruising, bleeding or infection, and the very rare possibility of more serious medical consequences of needle punctures such as pneumothorax or nerve damage. As with any medical procedure there is also the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.

3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.

4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis.

5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

6. I understand that the fees charged for my treatment are not covered under OHIP and must be paid in full at the end of each visit.

7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Patient Signature _____ Date_____

Practitioner Signature _____ Date_____

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