the naturopathic care centre

Please Read First

Dear Parent,

Thank you for making an appointment with me to discuss and improve your child's health. I congratulate you on your decision to take steps toward improved well-being. In return, I commit to helping you and your family, achieve your health goals. I will also help you learn and understand what is going on in your child's system in order for us to work together to correct any imbalances that are presently causing their 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 child's 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 your child.

Please read and complete the materials in advance of your appointment. ***YOU WILL HAVE TO START THE DIET SURVEY PROMPTLY*** *as this requires a week of careful attention (while being sure to reflect your child's usual dietary habits). If you reach a question you do not know the answer to, simply leave it blank and we can talk about it in the consultation.*

Please fill out forms to the best of your ability and bring completed forms with you to initial consultation. If you have copies of any recent medical test results that are relevant, please bring them along to your appointment. Also, please bring any supplements your child is taking currently (such as multivitamins, probiotics, herbs).

Naturopathic medicine is an individualized approach to primary health care and is unique in its integrated approach to health. It is the art, science and practice of preventing, diagnosing and treating conditions of the human mind and body through the use of natural substances and non-invasive treatments.

Naturopathic doctors are primary-care physicians who are trained at accredited medical colleges in a four-year full time program. Naturopathic doctors have extensive academic and clinical training with respect to the therapeutic use, contra-indication, possible adverse reactions and toxicities of natural remedies.

Naturopathic doctors work with their patients to prevent and treat acute and chronic illness. We restore health and establish optimal fitness by supporting the body's ability to heal through natural treatments and by treating the underlying cause of the illness rather than simply eliminating or suppressing symptoms.

Treatments used in our practice include: clinical nutrition and supplementation, homeopathy, botanical medicine, acupuncture, hydrotherapy and lifestyle counselling. Treatments are selected based on the individual needs of each patient, if you have a particular interest in one or more of these treatment modalities please discuss it during your consultation.

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

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

2025 Fee Schedule and Office Policies
Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.

Naturopathic Visits for Children (in person or phone/video visits)

Initial Consultation, adults and children (up to 60 minutes)	$240
Second Visit (up to 45 minutes)	$175
Extended Second Visit (up to 60 minutes)	$215
Naturopathic Consultation (up to 30 minutes)	$120
Naturopathic Consultation (up to 45 minutes)	$170
Naturopathic Consultation (up to 60 minutes)	$215
Naturopathic Consultation (up to 15 minutes)	$ 75
Naturopathic Consultation (5 minutes)	$ 25
Naturopathic Re-Assessment (18 months since last appointment) 45-60 min	$215

Services and Fees

Cancelled Appointment - with less than 48 hours notice	50% of originally scheduled visit
Missed Appointment - without notice	100 % of originally scheduled visit
Simple doctor's notes and prescription refills without office visit	$ 25
Email consults and comprehensive medical forms and reports	fee based on complexity/time

Within one business day of booking a new patient visit, $120 deposit is required to finalize the booking (instructions on how to pay in your booking confirmation). This $120 will be used toward payment for your first visit. **If this deposit is not received within 48 hours of booking your appointment, your appointment will be cancelled.** If a new patient visit is rescheduled more than 48 hours before a new patient booking this deposit can be transferred to a rescheduled appointment. Cancellations or rescheduling with less than 48 hours notice before an appointment will forfeit this deposit as per our cancellation policy.

We request a minimum of 48 hours notice for all types of visits if you cannot keep your appointment. Our answering machine and email are available during times when our office is closed. If you would like to reschedule 3 days or more before your appointment this can be done through our online booking. Adequate notice allows us to fill the time set aside for your appointment with a patient on our wait list.
Cancellations with less than 48 hours notice will be charged 50 % of scheduled visit cost. If your appointment is missed without a cancellation call or email you will be charged 100% amount of the visit. We do understand extenuating circumstances might apply which may make 48 hours notice impossible and take these under consideration when enforcing our late cancellation policy (emergencies/illness/weather/unforeseen events). There is never a charge to change an in person visit into a virtual visit which can be conducted by phone or through video. 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 at times in patient care and in these circumstances; we appreciate your patience and understanding.

All consultation services are not currently subsidized by OHIP. All naturopathic & acupuncture visits are exempt from HST.
Fees for health services and supplements are due when services are rendered and may be paid by cash, Visa, MasterCard or Debit. **We ask all telemedicine patients to have a valid credit card number on file with our office.**

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 may be subject to a fee depending on length of time required. Telephone calls and emails that require more than 5 minutes from our Naturopathic Doctor/Acupuncturist will be billed as consultations.

I have read and fully understood this fee schedule and office policies and I accept the terms outlined. In the case of a no show or last minute cancellation I accept the fees associated and authorize the charges.

Parent(s) or Guardian(s) Name _____

Parent or guardian's signature _____ Dated _____

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

Child New Patient Intake Form Date: _____

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Weight: _____ Height: _____
City: _____ Postal Code: _____
The child lives with (circle all applicable): mother father both parents other _____
Parent #1: _____ Phone: _____ Email: _____
Parent #2: _____ Phone: _____ 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

How may I help you? (your child's main concern): _____

Describe carefully any factors that you may suspect have played a role in the onset and perpetuation: _____

Have you attempted to treat this in the past? If so, what treatments have you tried? What were the results? _____

What seems to make it better? _____
What seem to make it worse? _____
Secondary concern(s)? _____

Have you consulted a medical doctor regarding your child's condition? Please explain his/her diagnosis, therapy and results: _____

Have you consulted a Naturopathic Doctor before? Yes No Who? _____
Have you consulted a Chiropractic Doctor before? Yes No Who? _____
Has your child been counselled in the past? Yes No Who? _____
What were the circumstances? _____

Please list the three most stressful events in your child's life (past or ongoing) _____

Please list any allergies/sensitivities and the symptoms they cause:
Drugs: _____
Foods: _____
Environment: _____

Family History: Please circle if there is any family history of the following conditions in your family

Heart Disease	MS	Diabetes	Thyroid Problems	Asthma
Tuberculosis	Alcoholism	Drug abuse	Rheumatoid arthritis	Allergies
Psoriasis	Eczema	Mental illness	Osteoarthritis	Kidney disease
Alzheimer's	Celiac disease	Depression	High blood pressure	Learning disability

Does cancer run in your family? If so, what type? _____
Other: _____

Do you know your child's blood type? (circle) A AB O B
List any hospitalizations and surgeries with approximate dates:

List any medical imaging (x-ray, CT, MRI, ultrasound, etc.) with approximate dates and reason for test:

List any past accidents or traumas with approximate dates:

Is your child vaccinated (please circle)?

Yes, regular pediatric schedule Yes, modified schedule Partially vaccinated Not vaccinated

Did your child ever have a reaction after any immunizations? Yes No

If so, which immunizations and describe the reactions:

Prenatal History

Were there any difficulties during pregnancy? Yes No

Please circle any experienced:

Gestational diabetes High blood pressure Thyroid conditions Toxemia Morning sickness
Threatened miscarriage Emotional trauma Physical trauma Bleeding Other:

Were there any interventions during the birth (i.e. Medications, epidural, forceps, vacuum, induction, C section)?

Were there any health problems after birth?

Was your child breastfed? Yes No If yes, how long?

Did your child drink formula? Yes No If yes, starting at what age and what type?

What foods were introduced first? When?

When was cow's milk introduced?

Is there anything excluded from your child's diet (i.e. vegetarian, food allergies)? If so, why?

How does your child eat? (good, picky eater, often, eats little, eats a lot)

How much does your child drink? What does he/she drink?

When did your child achieve developmental milestones(circle) Early Average Late

How many hours of sleep does your child get per night? Does it seem restful?

Does your child have siblings? If so, what are their ages?

Please check any of the following your child has had in the past:

□ Diaper rash	□ Seizures	□ Strep throat	□ Weight loss/ failure to thrive
□ Fears (specify)	□ Bladder infections	□ Colic	□ Allergies
□ Eczema	□ Whooping cough	□ Frequent colds	□ Swollen glands
□ Frequent diarrhea	□ Asthma	□ Ear infections	□ Worms/parasites
□ Constipation	□ Psoriasis	□ Chicken pox	□ Motion sickness
□ Cradle cap	□ Headaches	□ Measles	□ Mumps
□ Cavities	□ Tummyaches	□ Excess perspiration	□ Bedwetting
□ Rubella	□ Bronchitis	□ Pneumonia	□ Chronic nasal congestion
□ Growing pains	□ RSV	□ Joint problems	□ Gas
□ Bloody noses	□ Fecal incontinence	□ Insomnia	□ Nightmares

□ Problems at school (specify)

□ Other:

Is there anything else that you feel is important but has not been asked?

MEDICATION & SUPPLEMENT HISTORY

NAME: _____ DATE: _____

Please record from the most recent to the most distant (past). The most important inclusions are the things your child is currently taking and the things your child has taken for a substantial length of time in the past. Please indicate *all natural remedies and pharmaceutical medications* (prescription and non-prescription) your child is currently taking and when they started them. Please continue on the back if necessary. Bring any containers of medication, supplements or vitamins you are taking now.

If you recall additional medications that your child took in the past please add them along with the approximate dates or length of time they were taken. Please include any reactions your child has experienced (positive or negative).

Drug or Natural Medication	Present/Past	Start Date	Stop Date	Reason for it and result

Diet Diary

Meal	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							
Water **Cups/day**							
Other **Beverages**							
Exercise **Type & Duration**							

Diet/Activity report: Please take the time to complete the following survey carefully and accurately. List in detail the quantity and exact nature of all foods and beverages consumed. (i.e. frozen, canned etc.). Please also include any condiments and/or fats in each meal or snack.

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Privacy of your child's personal information is an important part of my clinic. My staff and I are committed to collecting, using and disclosing your child's personal information responsibly. All staff members are aware of the sensitive nature of the information that you have disclosed to us and are trained in the appropriate use and protection of your information. We promise that only necessary information is collected about your child and we only share their information with your consent. The Naturopathic Care Centre will be the health information custodian of your child's patient file. Our storage retention and destruction of their personal information complies with existing legislation with the College of Naturopaths in Ontario.
This clinic will collect, use and disclose your child's information for the following purposes:

- ❑ To assess their health concerns and provide health care
- ❑ To establish and maintain contact with you, or send newsletters
- ❑ To communicate with other health-care providers only with your consent
- ❑ To allow us to efficiently follow-up for treatment, care and billing
- ❑ To invoice for goods and services and to process credit card payments

INFORMED CONSENT TO TREATMENT
This is to acknowledge and declare that I understand that:

- ❑ Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional, spiritual and environmental factors, all of which play a role in an individuals' health. Gentle, non-invasive modalities of treatment are employed to stimulate the body's inherent healing capacity. These modalities include, but are not limited to, diet and nutritional supplements, botanical medicine, homeopathy, acupuncture, hydrotherapy, massage, physical medicine and lifestyle counseling.
- ❑ As a patient of The Naturopathic Care Centre, I hereby acknowledge that I am willing to provide an N.D. with the information necessary for them to fully understand my child's medical history, presenting symptoms and health goals I wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination.
- ❑ Any treatment or advice provided to me as a patient of Dr. Carrie Meszaros, N.D., R.Ac. 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 practitioner. I have the option to seek or continue conventional medical care from a conventional medical doctor. Dr. Carrie Meszaros, N.D., R.Ac. does not suggest to me to refrain from seeking or following conventional medical treatment if I choose to do so.
- ❑ It is my responsibility to maintain contact with a Medical Doctor (if applicable) so that all necessary testing may be performed as required to monitor my child's condition.
- ❑ Doctors of Naturopathic Medicine may use testing procedures that are not conventional to make an assessment of the progress of their therapies.
- ❑ Dr. Carrie Meszaros, N.D., R.Ac. does not treat cancer, auto-immune disease, genetic disease, HIV/AIDS etc., rather will help assess and correct imbalances in your child's body, nutrition and lifestyle so that their body can then achieve a state of better health.
- ❑ I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Naturopathic Medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, and interactions with prescription medications.
- ❑ As with all forms of therapy, I understand that naturopathic treatment also has its limitations and thus I understand that the results are not guaranteed. Dr. Carrie Meszaros N.D., R.Ac. will make every attempt to explain likely risks and side effects of treatment, I acknowledge that not all risks and complications can be predicted prior to beginning new treatments.
- ❑ With this knowledge, I voluntarily consent to Naturopathic Care for my child and I intend for this consent form to cover my child's entire course of treatment. I understand that I am free to withdraw my consent at any time.
- ❑ In the event of a medical emergency, I am advised to seek conventional medical care at a hospital.
- ❑ I agree to pay my account in full at every visit and whenever remedies are purchased.

If your child lives in two households and both parents have input in medical decision making, please ask the parent(s) from the other household to also sign this consent form. If this isn't possible, please bring a copy of your custody agreement to the first visit or send a copy to our office.
Household #1:

Parent(s) or Guardian(s) Name _____

Parent or guardian's signature _____ Dated _____

Household #2
Parent(s) or Guardian(s) Name _____

Parent's or guardian's signature _____ Dated: _____

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