Gaia Integrative Clinic
blending science and nature

Adult-Patient Information and Consent Form

Please complete the following information in full:
☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: ☐ Male ☐ Female Date of Birth: _____
Month / Day / Year

Work Phone: _____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number: _____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Primary Practitioner: _____
Family Doctor
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
☐ Referral ☐ Website ☐ Newspaper ☐ Yellow Pages
☐ Advertisement ☐ Friend/Family ☐ Other: _____

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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____
Patient's Name

_____ _____
Patient's Signature Date

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