

The Clinic Standard Policy

Access to Your Personal Information

It is your right to full access to personal information about you contained in our record if there is no legal or ethical reason that would prevent us from doing so. Fees associated with the copying and transfer of your medical files will be charged to supply the information requested by you.

If providing you with your personal information would also reveal someone else's personal information, we may have to remove that patient's information in order to protect patient confidentiality.

Use & Disclose Your Personal Information

Most of your personal information is directly provided by you to your physician. We sometimes have reports from other physicians or hospitals that have provided you with treatment. We are authorized by law to disclose your personal information in an emergency, primarily for your protection. There may also be circumstances where we are required by law to disclose your information to public health authorities.

Accuracy of Your Personal Information

The Practice wants to ensure that personal information about you which is maintained by us is accurate, complete and current. We do not routinely update personal information unless we need to for providing treatment or administering your care. Please help us in our commitment by letting us know of any changes to information provided by you. Keeping your personal information updated is of the utmost importance when we need to contact you or your contacts, in circumstances where contacts need to be made as soon as possible.

Your personal information is retained for 10 years from the date of your last visit/ encounter with the physician(s).

Appointment Cancellation and Non-Attendance Policy

The Practice strives to provide our patients with the very best in medical care. We respect our patient's time and effort to make their medical appointments at the appropriate time. We also expect our patients to respect the time and effort of The Practice in scheduling appointments. It is required that you give a minimum of 24 hours notice in order to cancel an appointment. We realize that unforeseen circumstances can occur that prevent you from giving sufficient notice for a cancellation or not attending an appointment. However, if a second scheduled appointment is not attended by you without prior sufficient notification, a charge of \$20.00 will apply.

Patient Consent Form

You are directed to Ontario's Health Information Privacy Legislation website here:

http://www.health.gov.on.ca/en/common/ministry/publications/reports/phipa/phipa_mn.aspx , which describes the kinds of personal health information that the Practice collects and how it uses and disclose health information.

I give my consent for my physician and employees who have a need to; collect, know use and disclose my personal health information as may be necessary.

My physician may disclose my personal information to consult with or to refer me for care by other physicians, nurses or other health care professionals.

My physician may disclose my personal information as may be necessary to advisors in the course of seeking treatment, risk management and medico-legal advice.

The Practice may conduct order and receive the results from diagnostic test, such as blood tests or x-rays which will assist in the diagnosis of illness.

The Practice may enclose my personal information to insurance companies if instructed by myself or government agencies that insure medical services.

I acknowledge that there may be certain circumstances where according to law, the Practice may collect, use or disclose my personal information about my consent.

I acknowledge The Practice's Service Policies concerning appointments and diagnosis protocol for Walk-In patients.

I acknowledge The Practice's Policies concerning non-Insured services and The Practice's appointment cancellation & Non-Attendance policy.

I consent to the following:

The Practice may contact me by telephone and leave a message on voicemail or in person for purposes such as appointments, reminders, insurance questions and related to my clinical care, including lab results.

I give the clinic staff and physicians at the clinic my consent to communicate and provide care using virtual and other telecommunications tools.

I understand the risks related to unauthorized disclosure or interception of personal health information and steps they I can take to help protect their information.

I understand that care provided through video or audio communication cannot replace the need for physical examination or an in-person visit for some disorders or urgent problems and the need to seek urgent care in an Emergency Department as necessary.

If the email is used as an e-communication tool, I understand that emails can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

While the clinic will attempt to review and respond in a timely fashion to your electronic communication, we can not guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.

I understand that I may revoke this consent in writing. If I do not accept this consent or later revoke it, The Practice may decline to provide treatment to me. Nevertheless I specifically agree that The Practice may retain a copy of my records as legally or professionally required.

By submitting your email address to us or signing hard copy of this letter, you agree to the terms and conditions provided here.