Optimal Health Directions
Naturopath

Date: ….. /…../……

Client Confidential Information (*please print*)

☐ Female ☐ Male

Full Name ……..…… Date of Birth …… /…… / ……..

Address ……

City / Suburb ……..….. State …… Post Code …….

Phone Number (mobile) …… (home) ……. (work) ……..……..

Email ……

Preferred to be contacted by: ☐ Mobile ☐ Home Ph. ☐ Work Ph. ☐ e-Mail ☐ Mail (post)

How did you hear about us? ☐ Website ☐ Social Media ☐ Family / Friend ☐ Other

Health Fund ……

Emergency Contact ……..…….. Relationship: …….. Phone ……..…

Practitioner	**Name**	**Address and Phone Number (if known)**
General Practitioner		
Medical Specialist		
Other		

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Known Allergies (please list):

……

……

……

Current Medications (*please also include any over the counter medications, vitamins and supplements*)

Medication / Supplement (e.g. metformin, cenovis multivitamin)	**Reason for Taking** (e.g. high blood pressure)	**Dosage** (e.g. 1 tab morning and night)	**Duration Taken** (e.g. 6 months)

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Informed Consent

Please note that this form *must* be signed prior to your first appointment.

Naturopathy uses holistic principles to treat the underlying cause, not just the symptoms. A Naturopath assesses the whole person taking into consideration physical, emotional, mental and spiritual aspects of the person, including environmental aspects. Prescribed treatments are gentle and non-invasive and aim to stimulate the body's inherent healing capacity. A Naturopath will take a thorough case history and may perform a physical examination and/or order laboratory tests, as required. It is important that you inform the Naturopath immediately of any disease processes or allergies from which you are suffering and any medications, including over the counter medications and supplements, that you are currently taking. Please advise the Naturopath if you are planning on conceiving, are currently pregnant or currently breast feeding.

As a client you will receive information about your health status, treatment plan, costs, expected benefits, potential risks and side effects. There is a slight risk of an adverse effect using naturopathic treatments, including, but not limited to:

- Allergic reactions to certain herbal medicines and supplements. It is important that you advise the Naturopath of any existing allergies you may have.
- Homeopathic remedies may occasionally result in an aggravation of pre-existing symptoms. Such aggravations typically only last for a short duration.

I, *(print full name)* ....., request and give consent to Socrates Mistos to perform health consulting ("Coaching") for myself, or the client named below for whom I am legally responsible. I understand that the consultation may consist of a physical examination and recommendations for further laboratory testing, as deemed necessary. I am informed and understand that if I am examined, I do so with consent. I understand that, although Socrates Mistos is a qualified Naturopath, during the consultation he does not practice medicine, diagnose or claim to cure. The information I receive is not intended to be a substitute for a consultation with my personal physician or medical specialist. I may choose to consult with my physician regarding the applicability of any of Socrates' recommendations with respect to any symptoms and/or medical conditions I have or treatment I am currently receiving. I understand that, as with all health care recommendations, the results are not guaranteed.

I am informed and understand that treatments and recommendations may involve certain risks. These may include, but are not limited to, digestive symptoms, fatigue, headaches, muscle and joint pain, and allergic reactions to herbs and supplements (these are statistical possibilities and not probable results). If these issues arise I will contact Socrates. In the case of an emergency, I will immediately contact my physician or an emergency facility.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to these conditions. I intend this consent to cover the entire course of consulting, including follow-up consultations now and in the future. I am responsible for all fees and agree that they are payable in full either prior to or at the end of each consultation performed.

- The Naturopath will explain to me the exact nature of any treatment plan provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

_____ _____ _____

Print Name | Signature of Patient/Guardian | Date

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Patient Consent for the Collection, Use and Disclosure of Personal Information

Please note that this form *must* be signed prior to your first appointment.

We are aware of and understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly.

Our privacy policy outlines what we are doing to ensure that:

- Only necessary information is collected about you.
- We will only share information with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.

We will collect, use and disclose information about you for the purposes to:

- Assess your health concerns.
- Advise you of treatment options.
- Establish and maintain contact with you.
- Send you information.
- Remind you of upcoming appointments.
- Communicate with other health-care providers (i.e. your G.P. or Medical Specialist), but only with your prior written consent.
- Allow us to follow up for treatment and billing.
- Complete health insurance claims.
- Invoice for goods and services provided.
- Process credit card payments.
- Collect unpaid accounts.
- Comply with regulatory and legal requirements including court orders and statutory requirements to advise authorities of child abuse and individuals who may pose a potential threat to harm themselves or others.

By signing this Patient Consent Form, you have agreed that you have given consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have read the above information that explains how my personal information will be used and the steps taken to protect my personal information. I agree and give my consent to the collection, use and disclosure of personal information about *(print full name)* ..... as set out above.

_____ _____ _____

Print Name Signature of Patient/Guardian Date