**Please read the following and initial in the space provided:**

\_\_\_\_\_ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent unless required by law.

\_\_\_\_\_ I understand that Dr Gallant will answer my questions to the best of his ability. I understand that results are not guaranteed. I acknowledge that Dr Gallant will do his best to anticipate and explain all of the risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned below, except for (please list any exceptions): Acupuncture and Cupping.

\_\_\_\_\_ I give Dr. Gallant permission to make physical contact with my person during the physical exam and when otherwise appropriate (e.g. acupuncture).

\_\_\_\_\_ I understand even though natural remedies are mostly safe, allergies and reactions may occur. Dr. Gallant will prevent this to the best of his ability but there is always possibility of adverse reactions. I will discontinue use of the suggested remedy and inform Dr. Gallant immediately, should an adverse reaction occur.

\_\_\_\_\_ I understand that I am at liberty to seek or continue to seek medical care from other health care providers who are qualified to practice in Ontario.

\_\_\_\_\_ I give permission to communicate via email or text with the awareness that these forms of communication are not 100% secure.

\_\_\_\_\_ I understand fees are to be paid for after each visit unless Dr Gallant is direct billing for me. 1 hour visits are $140 and 30 minute visits are $80.

\_\_\_\_\_ I understand the Naturopathic Doctor will not communicate with my Medical Doctors unless I give permission, I sign a Release of Records form or in emergency.

\_\_\_\_\_ I give Dr. Gallant permission to discuss my case with his associates (please circle): Dr. John Millett, Katrina Bem, Dr. Nicole Albuquerque, Dr. Julie Cull, Jessica Dargavel, Cristina Di Stefano, Julie Robinson.

\_\_\_\_\_ I give Dr. Gallant permission to discuss my case with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (spouse, family member, doctor, other)

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment under the care of Dr Gallant. I understand that I am free to withdraw my consent and to discontinue participation in Dr Gallant’s care at any time.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Naturopathic Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_