



## HOLISTIC HEALING ARTS

274 King George Rd., Unit 2

Brantford, ON N3R 5L6

519-751-3488 [www.ndoc.ca](http://www.ndoc.ca)

*Your Natural Path to Wellness*

### STATEMENT OF ACKNOWLEDGEMENT

Welcome to the Holistic Healing Arts. The Naturopathic system of health care is centered around and supportive of your body's own ability to heal. Naturopathy uses noninvasive methods for the assessment of bodily functions and natural therapies for correction, including dietary recommendations, lifestyle changes, acupuncture, bodywork, and remedies and/or supplements.

Each person seeking care in our clinic should understand that we are naturopathic doctors and not medical doctors. We work within a naturopathic scope of practice. If conventional medical treatment is desired, it must be obtained from a licensed medical doctor. We encourage you not to abandon contact with your medical doctor. Treatment and referral to other health practitioners, if needed, is based upon clinical assessment and laboratory testing.

If at any time, during your course of treatment, you would like to receive services from a different clinician, please ask. In order to maintain consistency and quality of care, an administrative fee will apply when transferring between naturopathic doctors.

There is an emphasis on patient education, as the ultimate responsibility for the patient's health is his/her own. Changes in dietary habits are not a prerequisite for treatment, but it should be understood that failure to follow sound nutritional and exercise programs could undermine the positive results.

The patient is responsible for any fees incurred during care and treatment and agrees to fully discharge this responsibility at the time of the visit. If you have not been in for an appointment in the last 24 months a reactivation fee will apply. **Also, when you give us less than 24 hours notice of cancellation, you will be charged a fee equal to the full cost of the appointment missed.** \_\_\_\_\_

The patient accepts or rejects this care of his/her own free will and choice.

I, \_\_\_\_\_ have read, understood, and acknowledge the above statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



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### **PRIVACY POLICY CONSENT FORM**

Our clinic understands the importance of protecting your personal information. Our privacy protocols comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of our regulatory body (College of Naturopaths of Ontario). This privacy policy outlines what Alfred Hauk, ND and Holistic Healing Arts are doing to ensure that:

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

### **COLLECTION, USE, AND DISCLOSURE OF PATIENT PERSONAL INFORMATION**

Alfred Hauk, ND will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment and care
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

Holistic Healing Arts will use and disclose contact information for the following purposes:

- To send you newsletters and other information mailings
- To remind you of upcoming appointments/ changes of appointments, missed appointments
- To allow us to efficiently follow-up for billing, products ordered
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts

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

I, \_\_\_\_\_ have read, understood, and acknowledge the above statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Holistic Healing Arts  
Alfred Hauk, N.D.