Consent to Participate In Telemedicine Consult and Electronic Communication

The purpose of this form is to obtain your consent to participate in telemedicine consultations and electronic communication with the following Naturopathic Physician at Back to Back Health/Nurture Naturopathic and Wellness, Inc:

Dr. Kyle Morrison ND

PHYSICIAN INFORMATION:

Name: Dr. Kyle Morrison, ND

Address: 591 Ledsham Rd. Victoria, BC V9B 6M2

Phone: 250-391-8761

Website: www.back2backhealth.com

The Physician has offered to communicate using the following means of electronic communication ("the Services"):

(Yes/No) Email	(Yes/No) Videoconferencing (including FaceTime®; Doxy.me®)
(Yes/No) Website/Portal	(Yes/No) Other (specify):

Conditions of using email or electronic device

The practitioner and clinic will use reasonable means to protect the security and confidentiality of email or electronic information sent and received. However, because of the risks outlined above, the practitioner nor the clinic cannot guarantee the security and confidentiality of email or electronic communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the practitioner. Thus, patients must consent to the use of email or electronic devices for patient information. Consent to the use of email and electronic device communication includes agreement with the following conditions:

• Emails or electronic communication to or from the patient concerning appointment bookings, billing, diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
• The practitioner and or clinic staff may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, health care operations, booking appointments, filing and other handling.
• Although the practitioner and or clinic staff will endeavour to read and respond promptly to an email or electronic communication from the patient, the practitioner or clinic cannot guarantee that any particular email or message will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.
• We do not offer medical treatment via email or electronic device. Email may be used to clarify current treatments.

• Email or electronic communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on the practitioner's or clinics email and for scheduling appointments where warranted.
• If the patient's email or electronic communication requires or invites a response from the practitioner or clinic and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.

• The patient should not use email or electronic devices for communication regarding sensitive medical information • The patient is responsible for informing the practitioner or clinic of any types of information the patient does not want to be sent by email in writing in addition to those set out in the bullet above.
• The practitioner or clinic is not responsible for information loss due to technical failures.
• The patient indemnifies the practitioner and clinic from all risks of breach of confidentiality associated with email or electronic communication. • Should the patient require immediate assistance, the patient should call the practitioner's office or clinic for consultation or an appointment, or take other measures as appropriate such as going to the nearest emergency department.

Appointment Reminders
Please check the box below if you give us consent to send you appointment reminders via email or electronic communication.

- o I wish to receive my appointment reminders and receipts via email or electronic communication. If I change my decision and prefer a phone call reminder or no reminder however it is my responsibility to contact the clinic and advise them that I am requesting this change.

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication. Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient name:

_____

Patient address:

_____

Patient home phone:

_____

Patient mobile phone:

_____

Patient email (if applicable):

_____

Other account information required to communicate via the Services (if applicable):

Patient signature:	Date:
Witness signature:	Date:

APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email used as an e-communication tool, the following are additional risks:

- Email can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email can be easier to falsify than handwritten or signed hard copies. 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.

Conditions of using the Services

- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot 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.
- If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and the Physician will not use the Services to communicate sensitive medical information about matters specified below:

(Yes/No) Sexually transmitted disease

(Yes/No) AIDS/HIV

(Yes/No) Mental health

(Yes/No) Developmental disability

(Yes/No) Substance abuse

Other (specify):

- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the Physician.
- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above: *(patient to initial)*

I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix.

Patient signature

Date

Patient Consent Form – Confidentiality Agreement

Privacy of your personal information is important to Back-to-Back Inc. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what Back-to-Back Inc is 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
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopathic Physicians of British Columbia

How our clinic collects, uses and discloses personal patient information:
Back-to-Back Inc. understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how Back-to-Back Inc. will use and disclose information. The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns and provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To communicate with other treating healthcare providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the College of Naturopathic Physicians of British Columbia, acting under the authority of the Health Professions Act
- To invoice for goods and services and to process credit card payments
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law

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

I have reviewed the above information that explains how Back-to-Back Inc. will use my personal information, and the steps Back-to-Back Inc. is taking to protect my information. I agree that Back-to-Back Inc. can collect, use and disclose personal information as set out above in the information about the Back-to-Back's privacy policies.

Print Name Signature Date

PATIENT INTAKE FORM

General Information
Patient name:_____ Date: _____
Date of birth:____/____/_____ (M/D/Y) Age: ____ Sex: M / F
Address:_____
_____
_____

Telephone number: Home:_____ Work:_____
E-mail address: _____ Cell: _____
Emergency contact Name: _____
Phone number: _____ Relation: _____

How did you hear about the Clinic?

Brochure	Yellow Pages	Family Doctor	BCNA
Television	Friend	Chiropractor	Directory
Radio	Relative	Specialist	Newspaper
Internet	Coworker	Health Professional	Health Food Store
Other:			

Other health care providers you are seeing:
1. _____
2. _____
3. _____
4. _____
5. _____

Please list your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Medical History

Describe your general state of health: Excellent ◯ Good ◯ Fair ◯ Poor ◯

Please indicate all past or current medical conditions, previous illnesses, injuries and or hospitalizations. Include approximate dates.

Do you have any allergies (medications, environmental, foods etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, Chinese patents etc.)

Have you ever had any adverse reactions to any medication, supplement, herb or Homeopathic?

Please list all past prescription medications, why you were taking them and for how long.

How many times have you been treated with antibiotics? _____

Female Patients

Are you currently pregnant? Yes / No

When was your last pap? _____ Have you ever had an abnormal pap? Y / N

When was your last breast exam? _____

What is your method of birth control? _____

Do you frequently use any of the following?

Alcohol—how much/day or week: _____

Tobacco—form and amount/day: _____

Caffeine—form and amount/day: _____

Recreational drugs—what and how often: _____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus
- ☐ Hepatitis A
- ☐ Influenza B
- ☐ Tetanus booster; when? _____
- ☐ "Flu"
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Polio
- ☐ Smallpox

Please indicate if any caused adverse reactions: _____

Diet

Do you have any food allergies or intolerances? What are your symptoms? Please list.

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)?

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snack _____

Family History

Indicate if a relative or family member has had any of the following:

		Who?			Who?
Allergies	☐		Cancer	☐	
Asthma	☐		Diabetes	☐	
Heart disease	☐		Drug abuse /alcoholism	☐	
High blood pressure	☐		Depression	☐	
Stroke	☐		Other mental illness	☐	
Kidney disease	☐		Other		

☐ I don't know my family medical history

Environment

Occupation _____
Hobbies_____
Do you exercise regularly? Y / N
What do you do for exercise, how much, how often? _____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals? Y / N
How old is your house? _____
How is your home heated? _____
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please describe? _____
_____

How would you describe the emotional climate of your home?
_____
_____

Do you have someone in your life you can talk to about your emotions? Family or friends whom are a support network? Y / N Whom? _____

Please rate your stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
How do you handle these stresses?
_____
_____

Have you ever experienced anything in your life that was traumatic to you? If you are able to comment on it, please write down a few points?

Is there anything that you feel is important that has not been covered?