15 - 1860 appleby line burlington ontario L7L 0B7
905.332.2828 info@imbuir.ca imbuir.ca
imbuir
integrative medicine + iV therapy

iV THERAPY INTAKE FORM

This intake form is a *confidential* health assessment tool designed to gain insight into your personal health status. When embarking on an individualized health plan it is important to begin with a thorough understanding of where you are currently, your personal and family history, as well as your habits, concerns, and thoughts with respect to your health. Please take the time to answer the questions on this form as genuinely and as accurately as possible.

PATIENT CONTACT INFORMATION

Patient Name: _____ **Date of Visit:** _____

Birthday: _____ **Age:** _____ MALE / FEMALE **Height:** _____ Weight: _____ Frame **S /M/ L**

Address: _____
Street Name Apt/Suite # City Postal Code

Home Tel #: (_____) _____ Mobile #: (_____) _____ **Work Tel #:** (_____) _____

Email address: _____@_____ **Best way to reach you:** _____

Status: SINGLE / MARRIED/ PARTNERED # of Children: _____ **Occupation:** _____

Referred by: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Tel #: _____

Please tell us the reason for your iV visit today

1) _____

MEDICAL HISTORY

Current /past illnesses, hospitalizations, surgeries, etc. Include dates.

_____

_____

_____

_____

Date of last Physical exam /Blood test: _____

Do you have any internal pins/wires, artificial limbs, special equipment?
Yes/No _____

Are you fully vaccinated? **YES / NO** Reactions/Notes? _____

Allergies/Sensitivities (foods, drugs, pets, seasonal, etc.):

_____

_____

LIST OF MEDICATIONS & NUTRITIONAL SUPPLEMENTS

(Please list conditions it treats)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Family Physician: _____ Specialty: _____ Phone number: (_____) _____

Address: _____ Fax number: (_____) _____

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imbuir™ PRIVACY & CANCELLATION POLICIES

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

The office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for naturopathic assessments.
- To collect information for nutritional and dietary assessments.
- To collect consultation or cancellation fees, and fees for supplements, food, and seminars.

As our valued patient we trust that you will appreciate a friendly reminder call or monthly newsletter via email in order to continue our relationship together during your personal health journey. ☐ If you wish to opt out of this program please check this box.

Your information will be disclosed as follows:

- To all health professionals and staff employed by imbuir
- To an emergency service personnel if one's life could be endangered.

We will only share your information with your consent, with the exception of the above. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDTN), the International Organization of Nutritional Consultants (IONC) and Ontario's Personal Health Information Protection Act (PHIPA).

At imbuir, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of $75 will apply. We hope you will appreciate this service as your time here at imbuir is valuable.

I have reviewed the above information that explains how Imbuir will use my personal information, and the steps that will be taken to protect my personal information. I agree that imbuir can collect, use, and disclose my personal information as set out above in the information about the clinic's privacy policies and charge a cancellation fee if I do not provide 24 hours' notice for a missed appointment.

_____ _____ _____

Signature Print Name Date

CONSENT TO DIAGNOSTIC/THERAPEUTIC PROCEDURES

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/therapeutic procedure(s) described by the attending practitioner, and have discussed to my satisfaction this and any requests for related information with the attending practitioner and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

Attending Practitioner(s): _____

Signature of Patient: _____ Date: _____

CONSENT TO NUTRITIONAL CONSULTING

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnoses, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Signature: _____ Date: _____

For Office Purposes Only

☐ Verbal consent acquired and witnessed. Patient understands and acknowledges risks and benefits to treatment explained.

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Parenteral Therapy Consent to Treatment

This form is to ensure that the undersigned understands that during the applications of intravenous, intramuscular or subcutaneous treatments, there are possible risks involved.

Do you have any of the following? (Please circle)

High blood pressure – pace maker – organ transplant – cancer – diabetes – mechanical obstruction (hips/screws, etc.) - allergic reactions to foods or medications – history of fainting – phobia of needles

Are you currently on any medications? _____

Possible reactions include but are not limited to:

1) **Bruising -** it is sometimes common for people to experience slight bruising after the treatment or a few days after a treatment has occurred. This can also include a hematoma.
2) **Fainting -** it is uncommon for people to experience fainting (due to reduced sugar levels, know as hypoglycaemia) while receiving IV or IM therapy. We ask our patients to eat around 1-2 hours before treatment.
3) **Feeling of Warmth -** a feeling of warmth is common for some people. The feeling can remain throughout the treatment but is not a concern. If the warmth continues, the treatment may be stop until the patient is ready to continue.
4) **Risk of Infection -** infection is very rare when disposable needles are used. The Clean Needle Technique (CNT) protocol greatly reduces the risk of infection and is both practiced and monitored at imbuir integrative medicine + iV therapy
5) ****Due to the sometimes high concentration of the iV contents, some patients may experience an "aching/cold/numb" sensation around the insertion site or in the arm being used for the insertion.** The application of heat or manual massaging of the affect arm can help alleviate this sensation.

I hereby acknowledge and understand that I will be charged for the contents of my infusion (iV) bag should I cancel my appointment within 24 hours of the scheduled appointment time. This fee is to be paid immediately upon cancellation of the appointment.

Signature_____ **Print Name**_____

Date_____

I hereby acknowledge and understand the above information, and give my consent to intravenous, intramuscular, subcutaneous or nebulising treatments by a licensed practitioner at imbuir integrative medicine + iV therapy.

Signature_____ **Print Name**_____

Date_____

☐ In office verbal review of the above consent to treatment form was conducted by a licensed imbuir integrative medicine + iV therapy practitioner

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CREDIT CARD PRE-AUTHORIZATION FORM
FOR MISSED APPOINTMENTS, AND PAST DUE STATEMENTS

We require your credit card information for several reasons:

1) If you miss an appointment without calling 24 hours in advance, then we charge your card a missed appointment fee of $75.00. This fee cannot be submitted to insurance.
2) If you miss an iV/injection appointment without calling prior to 9 am on the day of the appointment, then we charge your card a missed appointment fee of $75.00 for infusions and $25 for injections. This fee cannot be submitted to insurance.
3) In the event that you have an outstanding balance past 30 days, then we will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call our office to make partial or full arrangements for payment.

Please complete the following:

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express account for an initial or recurring charge of $75.00 for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 30 days. I realize I will only be charged for outstanding balances past 30 days if I have not made any payment arrangements with the billing department.

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express for an initial or reoccurring charge of $75 for any missed iV appointments and $25 for any missed injection appointments that are NOT cancelled prior to 9 am on the date of the appointment.

◯ I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges (“charge back”) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize imbuir – naturopathic medicine + iV therapy to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

_____
Client Name

_____
Cardholder Name

_____
Cardholder Billing Address City Province Postal Code

_____ _____
Account Number Expiration Date

_____ _____
Cardholder Signature Date