

CLIENT INTAKE FORM

Full Name _____

Health Care # and Province of issue _____

Date of Birth (MM/DD/YYYY) _____ Age _____ Sex: M | F

Home Address _____
City/Town, Province Postal Code

Home Phone (_____) _____ Mobile Phone (_____) _____

May we leave a detailed message on your personal voicemail? Yes | No

May we contact you at work? Yes | No

Do you have any other specific details in regards to phone calls you would like to share?

E-mail Address _____

Employer/School (if student) _____

Work/School Phone (_____) _____

Occupation _____ Employment Status _____

Emergency Contact _____ Phone (_____) _____

How did you hear about us?

Radio | Newspaper | Walk-In | Website | Friend/Relative | Other _____

Do you wish to be added to our email list to receive Gaia Newsletters*? Yes | No

*Please check your inbox to confirm your subscription.

Any questions/concerns?

NEW PATIENT AGREEMENT

At Gaia Collaborative Medicine Inc. (GCM) we believe strongly in empowering our clients to make choices that inspire new levels of total self-care to improve their quality of life. Therefore, it is essential to understand that the client is responsible for making decisions and guiding their care with the support of the GCM team. This requires the client to commit to improving their health and wellness by aspiring to balance the body, mind and spirit and to take ownership of their health.

GCM is committed to providing its client(s) with opportunities to improve their health through association with a team of qualified health practitioners. We pride ourselves on delivering continuous education, personal attention and consistent communication to our clients and to the general public. We also pride ourselves on taking the time required for our team of practitioners to study, develop and grow their own. If GCM is unavailable to attend to an emergency, it is the client's responsibility to ensure their immediate needs are met (i.e. visit the nearest hospital emergency room).

PAYMENT TERMS: Full payment is required at the end of each appointment or the beginning of each program. Visa, Mastercard, American Express and Debit are accepted but not personal cheques. Financing arrangements can be requested on an individual basis.

24-HOUR CANCELLATION POLICY: 24-hour notice is required for all booked appointments. Failure to notify GCM within this time period will result in the full amount of the service being charged to the client.

INFORMED CONSENT: I verify that all the information presented to GCM in my medical history is true and complete to the very best of my knowledge.

I agree to inform the Physician and/or Practitioner of any changes to my health status including changes in symptoms, medications or other treatments, and understand that failure to do so may severely compromise my care.

I understand that protocols need to be followed as recommended. No promises or guarantees have been made regarding their anticipated outcome.

I understand that selected practices are undergoing research and evaluation within the scientific and medical community and are not considered conventional care or treatment. I understand that some practices are currently unproven scientifically and could have no effect on changing the status of my condition.

I understand GCM reserves the right to refuse service.

I agree to allow my medical information to be shared among the health care practitioners at Gaia Collaborative Medicine Inc.

I certify with my signature below that I have read and understand the above terms and conditions of Gaia Collaborative Medicine Inc.

Name: _____

Signature: _____
(name & signature of parent or guardian)

Date: _____

Witnessed by: _____

Signature: _____

Date: _____