Cyndi Gilbert B.A.(Hons), ND
Naturopathic Doctor

Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. 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 our clinic 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 Board of Directors of Drugless Therapy – Naturopaths (BDDT-N)

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

This clinic will collect, use and disclose information about you for the following purposes:

To assess your health concerns	To advise you of treatment options
To provide health care	To establish and maintain contact with you
To distribute health care information to you	To book and confirm appointments
To communicate with other treating health-care providers	To allow us to efficiently follow-up for treatment, care and billing
For teaching and demonstrating purposes on an anonymous basis	To invoice for goods and services
To complete claims for insurance purposes	To process credit card payments
To collect unpaid accounts	To comply generally with the law
To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale	To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N)

By signing the consent section of this 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. If new purposes arise, we will seek your approval in advance.

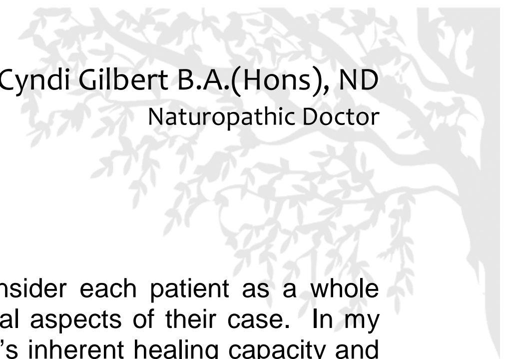
Patient Consent

I have reviewed the above information that explains how the naturopathic doctor will use my personal information, and the steps the clinic is taking to protect my information. I agree that Cyndi Gilbert, ND can collect, use and disclose personal information about ______________________ as set out above in the information about the clinic's privacy policies.
(Print patient name)

______________________ ______________________
Print name of patient or guardian Signature

______________________ ______________________
Witness Date

166 Montrose Ave., Toronto ON, M6J 2T8
Phone: 416.817.2385 Fax: 416.536.5063
Email: cyndi@cyndigilbert.ca
www.cyndigilbert.ca



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Welcome to my naturopathic practice. As a naturopathic doctor, I consider each patient as a whole person, taking into consideration physical, mental, emotional and spiritual aspects of their case. In my practice, I use a variety of naturopathic approaches to facilitate the body's inherent healing capacity and assist in the restoration of health.

Statement of Acknowledgement

I, _________________________, authorize Cyndi Gilbert, Naturopathic Doctor, to examine and administer Naturopathic care and treatment to _________________________, whose relationship to me is as a __________________________.

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment. I authorize Cyndi Gilbert, Naturopathic Doctor, to take whatever measures he/she considers necessary or desirable in connection with such naturopathic care and treatment.

This consent is modified as follows:
____
____
____

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

Name of Parent or Guardian ____
Address ____
____
Phone Number ____

I intend this consent form to cover the entire course of treatment. I accept full responsibility for any fees incurred during care and understand that payment is due at the time of service. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

________________________________ ________________________________ ________________
Signature of Parent or Guardian Witness Date

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