



Please Read First

Dear New Client,

Thank you for making an appointment with me to discuss and improve your health. I congratulate you on your decision to take steps toward improved well-being. In return, I commit to helping you achieve your health goals and to help you learn and understand what is going on in your system in order for us to work together to correct any imbalances that are presently causing your health challenges.

I would appreciate your careful consideration in answering the questions in the enclosed forms. By completing these forms with as much information as possible it will improve the accuracy of your assessment and allow us to have a more effective consultation. This reduces the need for extended consultation time and this subsequently saves you money and improves the care that I can provide for you.

*Please read and complete the materials in advance of your appointment. **YOU WILL HAVE TO START YOUR DIET SURVEY PROMPTLY** as this requires a week of careful attention (while being sure to reflect your usual dietary habits). If you reach a question you do not know the answer to, simply leave it blank and we can talk about it in the consultation.*

Please fill out forms to the best of your ability and bring completed forms with you to initial consultation. If you have any recent medical test results that are relevant, please bring them along to your appointment. Also, please bring any supplements you are taking currently.

Naturopathic medicine is an individualized approach to primary health care and is unique in its integrated approach to health. It is the art, science and practice of preventing, diagnosing and treating conditions of the human mind and body through the use of natural substances and non-invasive treatments. Naturopathic doctors are primary-care physicians who are trained at accredited medical colleges in a four-year full time program. Naturopathic doctors have extensive academic and clinical training with respect to the therapeutic use, contra-indication, possible adverse reactions and toxicities of natural remedies.

Naturopathic doctors work with their patients to prevent and treat acute and chronic illness. We restore health and establish optimal fitness by supporting the body's ability to heal itself through natural treatments and by treating the underlying cause of the illness rather than simply eliminating or suppressing symptoms.

Treatments used in my naturopathic practice include: clinical nutrition and supplementation, homeopathy, botanical medicine, acupuncture, hydrotherapy and lifestyle counselling. Treatments are selected based on the individual needs of each patient, if you have a particular interest in one or more of these treatment modalities please discuss it with me during our consultation.

Thank you for your time in advance, and I look forward to working together to achieve your optimum health.

Carrie Meszaros, B.Sc. (Hons.), N.D.



Fee Schedule and Office Policies

** These services are **not currently subsidized by OHIP**

** Prices listed do not include the HST

Initial Consultation – adult - (1 hour)	\$140.00
Initial Child Consultation – child – (45 – 60 min)	125.00
Second Visit (45 minutes)	105.00
Naturopathic Consultation (1/2 hour)	70.00
Naturopathic Consultation (45 minutes)	95.00
Naturopathic Review (10-15 minutes)	40.00
Naturopathic Re-Assessment (18 months since last appointment)	105.00
Initial Acupuncture and Consultation	70.00
Acupuncture + Short Consultation	70.00
Acupuncture without Consultation	55.00
Doctor's Notes	15.00
Cancelled Appointment (with less than 24 hours notice)	30.00
Missed Appointment (with no notice)	40.00

Lab Services

ZincTally Test	5.00
Koenisburg Test	7.50
Urinary Indican	14.00
HCG	12.00
Blood Type Test	7.00
Oxidata	16.50
Dip	7.00

Fees for health services and supplements are **due when services are rendered** and may be paid by cash, cheque, Visa, Mastercard or Debit. There will be a \$20.00 fee for NSF cheques.

We respectfully request a **minimum of 24 hours notice** in the event you cannot keep your appointment. **Without minimum notice we will charge \$30.00 for the appointment.** Our answering machine is available during off hours to take any messages.

If an appointment is missed without a cancellation call, you will be charged \$40.00.

For the respect and convenience of our clients and for efficient operation of our clinic, we endeavour to keep scheduled appointments on time. However, complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding. **Please note that when you arrive late for your appointment, only the balance of time that was booked for you can be used.**

Telephone consultations provide a professional service and as such may be subjected to a fee on the discretion of the Naturopathic Doctor.

Carrie Meszaros, B.Sc. (Hons.), N.D.

I have read and fully understood the above description of this fee schedule and office policies and I agree to honour it
_____ clients or guardians signature

Patient Intake Form

Carrie Meszaros, B.Sc. (Hons.), N.D.

Date: _____

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City: _____ Postal Code: _____
Phone: Home: _____ Work: _____ Height: _____ Weight: _____
Occupation: _____ How did you hear about the clinic? _____
E-Mail Address: _____ Would you like our E-newsletter? _____
In Case of Emergency: _____ Phone: _____
Doctor: _____ Phone: _____

How may I help you? (Your main concern): _____

Describe carefully any factors that you suspect may have played a role in the onset and perpetuation: _____

What are the most significant measures you have taken to improve your state of health? _____

Is your health currently getting better, worse or staying the same? _____
What seems to make it better? _____

What seems to make it worse? _____

Have you consulted a medical doctor regarding your condition(s)? Explain his/her diagnosis, therapy and results: _____

Have you consulted a Naturopathic Doctor before? Y N Who? _____
Have you consulted a Chiropractic Doctor before? Y N Who? _____
Have you consulted a Massage Therapist before? Y N Who? _____
Are you currently working with a professional counsellor, psychologist or psychiatrist, etc.? Y N
Have you been counselled in the past? Y N What were the circumstances? _____

Please list the three most stressful events in your life (past or present): _____

What is the level of stress in your life presently on a scale of 1 – 10? _____

Please list below any allergies/ sensitivities and the symptoms they cause:
Drugs: _____

Foods: _____

Environment: _____

Family History: Please circle if there is any history of the following conditions in your family

Heart Disease	Alzheimers	Diabetes	Thyroid Problems	Asthma
Tuberculosis	Alcoholism	Drug Abuse	Rheumatoid Arthritis	Allergies
High Blood Pressure	Eczema	Osteoarthritis	Celiac Disease	Kidney Disease
Mental Illness	Depression	MS	Psoriasis	Learning Disability

Does cancer run in your family? _____
Other: _____

Personal Medical history
List any hospitalizations, surgeries (date/ why?)

Please circle your blood type: A B O AB
List X rays, CT scans, MRI's (date/ why?)

List any past trauma or accidents with the date: _____

Childhood History:

Were you breastfed? Y N For how long? _____

Were you bottle-fed? Y N For how long? _____

Are you immunized? Y N If yes, did you have any reaction? _____

Was your birth process natural? Y N Were there any complications? _____

Which childhood illnesses did you have? Please circle

Polio	Chicken Pox	German measles	Ear Infections	Colic
Mumps	Rheumatic Fever	Whooping Cough	Allergies	Worms
Red measles	Eczema/rashes	Frequent Colds	Bronchitis/Pneumonia	
Other?	_____			

1. Have you ever suspected or been diagnosed with parasites? Y N

2. Have you ever had Mono (Epstein Barr Syndrome)? Y N

3. Have you ever been diagnosed with?

Heart Trouble Y N Diabetes Y N

AIDS Y N Circulation Problems Y N

Thyroid Disease Y N Cancer Y N

Arthritis Y N Autoimmune Disease Y N

4. What do you feel is your weakest organ system and why? _____

5. How many times a year do you have a cold, sinusitis, sore throat, bronchitis or the flu? _____

How long do they last? _____

6. Do you wear a Medical Alert bracelet or tag? Y N For what condition? _____

7. Do you drink purified/filtered water? Y N What type? _____

8. Do you drink 6-8 glasses of water per day Y N How many do you drink? _____

9. Do you exercise regularly? Y N What type and Frequency? _____

10. Do you smoke? Y N When did you start and how much do you smoke? _____

11. Do you drink alcohol? Y N Frequency? _____

12. Do you take recreational drugs? Y N What type and frequency? _____

13. Are you on a special diet? Y N Explain: _____

14. Do you have any cravings? Y N Specify: _____

15. How many hours of sleep do you get? _____ Is it restful? _____

Do you wake in the night? _____ If so, is it at a particular time? _____

16. How many children do you have? _____ Do they live with you? Y N

17. Marital Status (circle) single married divorced separated widowed with partner

18. Is your job associated with potentially harmful chemicals (i.e. Pesticides, Solvents, Radioactivity) or health and/or life threatening activities (i.e. mining, firefighting) Specify: _____

19. What time of day do you have the most energy? _____

20. What time of day do you have the least energy? _____

21. What do you do to relax? _____

How often do you take the time for relaxation? _____

Is there anything else that you feel is important that hasn't been addressed? _____

Review of Systems

Mark with the appropriate letter

F=frequency

O=occasionally

P=past

N=never

If there are any conditions you are unfamiliar with or that you have questions about, please indicate below. Your Naturopathic Doctor will discuss them with you during your appointment.

Skin

- _____ rashes
- _____ eczema
- _____ psoriasis
- _____ hives
- _____ acne
- _____ boils
- _____ changes in moles
- _____ skin cancer
- _____ dry skin
- _____ itchy skin
- _____ night sweats

Eyes

- _____ near sighted
 - _____ far sighted
 - _____ eye pain
 - _____ double vision
 - _____ blind spot
 - _____ glaucoma
 - _____ cataract
 - _____ blurry vision
 - _____ dry eyes
 - _____ itchy eyes
 - _____ tearing
 - _____ red eyes
 - _____ discharge
 - _____ thinning eyebrows
- Other: _____

Head and Neck

- _____ headache
- _____ migraines
- _____ dizziness
- _____ dizziness upon rising
- _____ trauma to head
- _____ excessive hair loss
- _____ excessive hair growth
- _____ dandruff
- _____ root canals
- _____ how many? _____
- _____ metal fillings
- _____ how many? _____
- _____ swelling of neck

Ears

- _____ ringing
- _____ impaired hearing
- _____ earache
- _____ discharge
- _____ dizziness
- _____ wax build-up
- _____ itchy

Peripheral Vascular

- _____ extremity swelling
- _____ varicose veins
- _____ spider veins
- _____ extremity numbness
- _____ extremity ulcers
- _____ deep leg pain
- _____ extremity coldness
- _____ phlebitis
- _____ raynode's syndrome
- _____ thinning body hair

Cardiovascular

- _____ high blood pressure
 - _____ high cholesterol
 - _____ angina
 - _____ heart murmurs
 - _____ rheumatic fever
 - _____ chest pains
 - _____ heart palpitations
 - _____ swelling of ankles
 - _____ abnormal heart tests
- Do you like your job? Y N

Urinary

- _____ frequent infections
- _____ pain/burning urination
- _____ increased frequency
- _____ increased urgency
- _____ incontinence
- _____ urination at night
- _____ kidney stones
- _____ hesitancy
- _____ strong urine odour
- _____ cloudy urine
- _____ bloody urine

Other: _____

Neurological

- _____ fainting
- _____ seizures/convulsions
- _____ tingling/numbness
- _____ involuntary movement
- _____ loss of balance
- _____ speech problems
- _____ loss of memory
- _____ paralysis

Other: _____

Musculoskeletal

- _____ joint pain or stiffness
- _____ joint swelling
- _____ osteoarthritis
- _____ rheumatoid arthritis
- _____ muscle cramps
- _____ backache
- _____ neck pain/stiffness
- _____ flat feet/ foot pain
- _____ sprain joints easily
- _____ heel spurs
- _____ gout

Upper Respiratory

- _____ frequent colds
- _____ frequent sore throats
- _____ tonsillitis
- _____ swollen neck glands
- _____ sinusitis
- _____ nasal discharge
- _____ post nasal drip
- _____ seasonal allergies
- _____ nosebleeds
- _____ coughing
- _____ sputum
- _____ hoarseness
- _____ wheezing
- _____ asthma
- _____ spitting up blood
- _____ shortness of breath
- _____ shortness of breath while laying down
- _____ pain on breathing
- _____ bronchitis
- _____ pneumonia
- _____ tuberculosis

Endocrine

- _____ thyroid problems
- _____ heat/cold intolerance
- _____ excess sweating
- _____ hypoglycemia
- _____ chronic fatigue
- _____ hormone therapy
- _____ diabetes
- _____ seasonal depression
- _____ shift work
- _____ worse if missing meals
- _____ recent weight gain _____ lbs.
- _____ recent weight loss _____ lbs.

Gastrointestinal

- food allergies
- heartburn
- hernia
- nausea
- vomiting
- excessive belching
- excessive gas
- bad taste in mouth
- bloating
- jaundice
- liver disease
- gallbladder disease
- gallstones
- worse from fatty food
- ulcer
- indigestion
- # of bowel movements/day
- loose stools
- hard stools
- mucus in stool
- blood in stool
- black tarry stool
- yellow/pale stool
- greenish stool
- undigested food in stool
- irritable bowel syndrome
- colitis
- crohn's disease
- rectal bleeding
- hemorrhoids
- anal fissures
- anal prolapse
- diarrhea
- abdominal pain
- stomach pain
- pancreatic disease
- painful bowel movements
- fecal incontinence
- celiac disease

Do you have any foods that upset your stomach?
Specify: _____

Other

- eating disorders
- Explain: _____

Motor vehicle accidents?
How many? _____
When? _____

Liquid Intake

- # _____ decaf. coffee/day
- # _____ regular coffee/day
- # _____ black/green tea/day
- # _____ herbal tea/day
- # _____ drinks of cola/day
- # _____ diet beverages/day
- # _____ cups of water/day
- # _____ others (juice, milk, pop)

Males Only

- prostate problems
- prostate surgery
- hernia
- testicular pain
- testicular masses
- discharge of sores
- venereal disease/STDs
- erectile dysfunction
- decreased sex drive
- increased sex drive
- elevated PSA

Last PSA: _____
Last prostate exam: _____

Emotional

- depression
- anxiety
- mood swings
- nervousness
- panic attacks
- irritable
- angry
- insomnia
- worrier
- forgetfulness
- phobias
- Specify: _____

Blood/Lymphatic

- anemia
- easy bruising
- easy bleeding
- past transfusions
- lymph node swelling
- lymphatic disease
- blood diseases
- wounds heal slowly

Other: _____

Females Only

- Y N Have your periods ceased?
- Y N Hysterectomy?
Why? _____

Y N Birth Control?
Type? _____

Age of 1st period _____
days of cycle (day1-day1)

- irregular cycles
- bleeding between periods
- PMS
- Symptoms: _____

- painful menses
- excessive flow
- scanty flow
- clots in flow
- fibroids
- endometriosis
- ovarian cysts
- cervical dysplasia
- cervical cancer
- ovarian cancer
- uterine cancer
- vaginal discharge
- vaginal itching
- vaginal dryness
- yeast infections
- vaginitis
- decreased sex drive
- increased sex drive
- pain on intercourse
- hot flushes
- night sweats
- estrogen replacement
- Type: _____

of pregnancies _____
of miscarriages _____
of abortions _____

- difficulty conceiving
- breast lumps
- breast tenderness
- breast implants
- nipple discharge
- sexual difficulties

Last PAP: _____
Last breast exam: _____
Other: _____

MEDICATION & SUPPLEMENT HISTORY

NAME: _____ DATE: _____

Please record from the most recent to the most distant (past), the most important inclusions are the things you are currently taking and the things you have taken for a substantial time. Please include any reactions you have experienced. Also please indicate those you are on presently, when you started them and approximately how long you were on various medications in the past. Please continue on the back if necessary. Please include all prescription and non-prescription medicines, herbal supplements and vitamins. Bring any containers of medication, supplements or vitamins you are taking now.

DRUG OR NATURAL MEDICATION	PRESENT/PAST	START DATE	STOP DATE	REASON FOR IT AND RESULT

Diet Diary

Meal	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							
Water Cups/day							
Other Beverages							
Exercise Type & Duration							

Diet/Activity report: Please take the time to complete the following survey carefully and accurately. List in detail the quantity and exact nature of all foods and beverages consumed. (ie: frozen, canned etc.). Please also include any condiments and/or fats in each meal or snack.

AXILLARY TEMPERATURE TEST

Name: _____ Date: _____

There is considerable evidence that the current tests for the diagnosis of hypothyroidism (low thyroid function) are insensitive and somewhat lacking in accuracy.

Broda Barnes, M.D. and Endocrinologist and thyroid specialist, in his book "Hypothyroidism, an Unsuspected Illness", explains his feelings and theories about this matter. He proposes that the most sensitive and accurate test for picking up the most people with low thyroid function is simply to check the most basic function of the thyroid. It's ability to regulate the metabolic furnace of the body, i.e. create heat or control temperature. Dr. Barnes feels that the recording of basal body temperature daily for six days is the most simple and best means of doing this. For accuracy, he insists that the patient is basal and totally relaxed.

Instructions are:

1. Use an oral mercury thermometer, which has been shaken down the night before or a digital thermometer that's meant for axillary or basal use. Put it on your bedside table before falling asleep.
2. When you wake up put the thermometer in your armpit (10 minutes for mercury or until it beeps if digital). Record a temperature each morning for six days. Do this before you have gotten out of bed, urinated, had coffee, had food, done any activity, mental or physical. An axillary (armpit) temperature is suggested, rather than the mouth, because so many people have low grade unsuspected sinus infections which generate heat only in that area, thereby falsely raising the oral temperature.
3. For women, additional consideration is needed during ovulation, which elevates temperature somewhat. Because of this, women who menstruate should start the recording on the second or third day of their cycle. For men, or women who are menopausal, it makes no difference which day is picked.

We are attempting to search out and find the undiscovered hypothyroidism that our patients have, since this is such a common and easily treatable ailment. Barnes estimates that approximately 40% of the adult population has this problem and it can be associated with hypoglycemia and allergies, Psoriasis, acne, undiagnosed skin problems, hypertension, obesity, depression and many other ailments. If you have any unusual reaction while this is going on, or anything you wish to share, please indicate this on the recording sheet.

DATE:	TEMPERATURE VALUE
1.	
2.	
3.	
4.	
5.	
6.	

Bring this into the office for the doctor to look over. 97.8 ° F or 36.5 ° C or below is considered abnormal. If the majority of the temperature data is low, it probably suggests low thyroid function.

DYSBIOSIS QUESTIONNAIRE AND SCORE SHEET

This questionnaire is designed for adults and the scoring system isn't as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeasts, fungi and other pathogens, (Section A) and symptoms commonly found in individuals with dysbiosis related illness (Section B and C).

For each "yes" answer in Section A, circle the Point Score in that section. Total your score and record it in the box at the end of the section. Then move on to Section B and C and score as directed.

Filling out and scoring this questionnaire should help you and your physician evaluate the possible role of dysbiosis in contributing to your health problems. Yet it will not provide an automatic "yes" or "no" answer.

Note: Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely affects other important organ systems via toxic stress and interfering with nutrient absorption and utilization.

Section A: History	Point Score		Point Score
1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for skin acne or anything else for 1 month or longer?	25	9. Does exposure to perfumes, insecticides, fabric shop odours and other chemicals provoke..... Moderate to severe symptoms? Mild symptoms? List symptoms	20 5
2. Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory urinary or other infections for 4 or more courses in a 1 year period?	20	10. Are you symptoms worse on damp, muggy days or in moldy places? List symptoms	20
3. Have you ever taken a broad spectrum antibiotic drug – even a single dose?	6	11. Have you had athlete's foot, ring worm, jock itch or other chronic fungal infections of the skin or nails? Have such infections been..... Severe or persistent? Mild to moderate?	Y/N 20 10
4. Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25	12. Do you crave sugar? 13. Do you crave breads? 14. Do you crave alcoholic beverages? 15. Does tobacco smoke really bother you?	10 10 10 10
5. Have you taken birth control pills? For more than 5 years? For more than 2 years? For 6 months to 2 years?	25 15 8	16. Have you consumed chlorinated (or chemically treated) drinking water for 3 or more months?	15
6. Have you been pregnant? 2 or more times? 1 time?	5 3	17. Do you consume commercially raised meats (antibiotic fed) on a regular basis?	15
7. Have you taken Prednisone, Decadron or other cortisone type drugs? For more than 6 months? For more than 2 weeks? For 2 weeks or less?	25 15 6	18. Do you eat processed foods regularly? 19. Do you drink alcohol or consume coffee daily? 20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis?	20 20 35
8. Have you ever had parasitic infections, dysentery or unexplained episodes of prolonged diarrhea and/or intestinal distress?	15	TOTAL SCORE, SECTION A	

Section B: Major Symptoms For each of your symptoms, enter the appropriate figure in the Point Score Column: If a symptom is occasional or mild score 3 pts. If a symptom is frequent &/or moderate score 6 pts. If a symptom is severe or disabling score 9 pts. Add total score and record it in the box at the end of this section.	Point Score	Section C: Other Symptoms For each of your symptoms, enter the appropriate figure in the Point Score Column: If a symptom is occasional or mild score 1 pt. If a symptom is frequent &/or moderately severe score 2 pts. If a symptom is severe or disabling score 3pts. Add total score and record it in the box at the end of this section.	Point Score
1. Fatigue or lethargy		1. Drowsiness	
2. Feeling of being “drained”		2. Irritability	
3. Poor memory		3. Lack of co-ordination	
4. Feeling “spacey” or “unreal”		4. Inability to concentrate	
5. Depression		5. Frequent mood swings	
6. Numbness, burning or tingling		6. Headache	
7. Muscle aches		7. Dizziness or loss of balance	
8. Muscle weakness or paralysis		8. Pressure above ears/feeling of head swelling and tingling	
9. Pain and/or swelling in joints		9. Itching	
10. Abdominal pain		10. Rashes	
11. Constipation		11. Heartburn	
12. Diarrhea		12. Indigestion	
13. Bloating		13. Belching and intestinal gas	
14. Troublesome vaginal discharge		14. Mucus in stool	
15. Persistent vaginal burning or itching		15. Hemorrhoids	
16. Prostatitis		16. Dry mouth	
17. Impotence		17. Rash or blisters in mouth	
18. Loss of sexual drive		18. Bad breath	
19. Endometriosis		19. Nasal congestion	
20. Cramps and/or other menstrual irregularities		20. Joint swelling or arthritis	
21. Premenstrual tension		21. Postnasal drip	
22. Spots in front of eyes		22. Nasal itching	
23. Erratic vision		23. Sore or dry throat	
24. Eczema, dermatitis, psoriasis		24. Cough	
		25. Pain or tightness in chest	
TOTAL SCORE, SECTION B		26. Wheezing or shortness of breath	
		27. Urgency or urinary frequency	
TOTAL SCORE, SECTION C		28. Burning on urination	
		29. Failing vision	
TOTAL SCORE, SECTION A		30. Burning or tearing of eyes	
		31. Recurrent infection or fluid in ears	
		32. Ear pain or hearing loss	
GRAND TOTAL SCORE, SECTIONS A, B & C		TOTAL SCORE, SECTION C	

The Grand Total Score will help you and your physician decide if your health problems are dysbiosis related. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men. Dysbiosis related health problems are **almost certainly** present in women with scores over 180, and in men with scores over 140.

Dysbiosis related problems are **probably** present in women with scores over 120, and men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.

CARRIE MESZAROS B.Sc., N.D.
288 Wellington St., Stratford, ON N5A 2L9

CONSENT TO USE AND DISCLOSE PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic. We are committed to collecting, using and disclosing your personal information responsibly. All staff members are aware of the sensitive nature of the information that you have disclosed to us and are trained in the appropriate use and protection of your information. We promise that only necessary information is collected about you and we only share your information with your consent. Our, storage retention and destruction of your personal information complies with existing legislation with the Board of Directors of Drugless Therapy – Naturopathy and Privacy protection protocol.

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

- To assess your health concerns and provide health care
- To establish and maintain contact with you, or send newsletters
- To communicate with other health-care providers only with your consent
- To allow us to efficiently follow-up for treatment, care and billing
- To invoice for goods and services and to process credit card payments

DECLARATION AND RELEASE: CONSENT TO TREATMENT

This is to acknowledge and declare that I have been informed of and understand that:

- Any treatment or advice provided to me as a client of Carrie Meszaros, N.D. is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care practitioner.
- I have the option to seek or continue conventional medical care from a conventional medical doctor. Carrie Meszaros, N.D. has not suggested to me to refrain from seeking or following conventional medical treatment.
- Doctors of Naturopathic Medicine are trained to read and interpret x-rays, ultra sounds and other conventional medical tests but are restricted from ordering them in the Province of Ontario. Therefore, it is my responsibility to maintain contact with a Medical Doctor so that all necessary testing may be performed as required to monitor my condition.
- Doctors of Naturopathic Medicine may use testing procedures that are not conventional to make an assessment of the progress of their therapies.
- Carrie Meszaros, ND does not treat cancer, auto-immune disease, genetic disease, HIV/AIDS etc., rather she will help me assess and correct imbalances in my body, nutrition and lifestyle so that my body can then achieve a state of better health.
- In the event of a medical emergency, I am advised to seek conventional medical care at a hospital.

I agree to pay my account in full at every visit and whenever remedies are purchased. I have read and understand the fee schedule that was given to me. I have read the attached information about naturopathic medicine. Treatment recommendations may include but are not limited to homeopathy, acupuncture, botanical medicines, vitamin and mineral therapy, nutrition, lifestyle counseling, stress management and physical therapies. I declare I have received a full and complete explanation of the treatment and/or services that I will receive from Carrie Meszaros, ND, and hereby authorize and consent to treatment by her.

By signing this form you have agreed that you have given your informed consent to treatment and to the collection, use and/or disclosure of your personal information.

Dated and signed this _____ day of _____, 20_____.

Client's Name (please print) _____

Client Signature (or signature of parent or guardian) _____

Doctor's Signature _____