Simmonds McMurrer Naturopathic Medicine

Dr.Kali Simmonds,N.D. Dr.Lana McMurrer,N.D. Dr.Nara Simmonds,N.D.
34 Queen Street, 2nd Floor Charlottetown, PE C1A 4A3
Tel.902.894.3868 Fax.902.894.4054
www.simmondsmcmurrer.com

ACUTE INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____Work Phone: _____ Email:_____

Occupation: _____ Employer: _____

Sex: M / F Marital Status: _____ # of Children: _____

Contact Person in case of Emergency: _____ Phone #: _____

Does your extended health care plan cover naturopathic services? Y / N

Date of last medical visit: _____ Reason: _____

Family physician: _____ Phone #: _____

Past injuries: _____ When? _____

_____ When? _____

Past surgeries: _____ When? _____

_____ When? _____

Allergies (please list):

_____

_____

What is your primary reason for visiting the doctor today?

_____

_____

Please list food supplements, vitamins, minerals, homeopathics, and herbs you currently take and indicate dosage:

_____ _____ _____

_____ _____ _____

Please list prescription and non-prescription medicines you currently take and indicate dosage:

_____ _____ _____

_____ _____ _____

AGREEMENT AND CONSENT TO TREATMENT

It is our pleasure to provide you with effective and quality health care. In order to do this, please understand the following policies and procedures:

Fee Schedule	
15 minute consultation	$40.00
30 minute consultation	$75.00

THIS IS TO ACKNOWLEDGE that I have been informed and understand:

1. Any treatment or advice provided to me as a patient of the Clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider
2. I understand that Naturopathic Medicine is a comprehensive approach to health and illness and focuses on prevention and the use of natural substances and treatments including: Clinical Nutrition, Lifestyle Counselling, Homeopathy, Chinese Medicine & Acupuncture Botanical Medicine, Physical Medicine & Hydrotherapy
3. I am at liberty to seek and/or continue medical care from a medical doctor or other qualified health care provider
4. I am aware that no part of my treatment or testing is covered by P.E.I. Medicare and that I am solely responsible for payment
5. Payment is to be made at the time of treatment

I HEREBY AUTHORIZE AND CONSENT TO NATUROPATHIC TREATMENT BY:

DR. KALI SIMMONDS, N.D. ___
DR. LANA MCMURRER, N.D. ___
DR. NARA SIMMONDS, N.D. ___

I understand and agree to the above policies and procedures:

Patient's Full Name (please print): _____
First Middle Last

Date of Consent: _____
Day Month Year

Signature: _____
Patient or legal guardian

How did you hear about us?

Advertisement / Word of Mouth / Walk-by / Referral / Other: _____

_____