CONFIDENTIAL MEDICAL HISTORY FORM

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All questions contained in this questionnaire are strictly confidential and will become a part of your Integrative Aesthetics record.

Personal Information		
Full Name:	Today's Date:	
Birthdate (mm/dd/yyyy):		
Address:	Postal Code:	Province:
Mobile #:	Home #:	

Emergency Contact:	
Relationship:	Contact #:

Would you like to receive newsletter emails (ie. health tips, upcoming events): ☐ YES ☐ NO

How did you hear about Integrative?

Appointment Reminders	
How would you like to receive reminders of your upcoming appointment? (choose 1 option)	
☐ Email	Email Address:
☐ Text	Mobile #:

Do you have any medical illnesses? If yes, please describe:

Do you take/use any pharmaceuticals, herbal or natural medicines, vitamins/minerals? Please indicate:

Do you have any allergies to medication? (incl. anesthetics, food, latex, other). Please indicate:

What is your chief complaint about the treatment area?

Have you had any of the following treatments? (check all that apply)

- ☐ Cosmetic Surgery
- ☐ Fillers
- ☐ Neuromodulator (specify: _____)
- ☐ Permanent Makeup
- ☐ PRP Facial Rejuvenation
- ☐ Other: _____

Please check any of the following which may be appropriate to you:

Medications/Topical Treatments	Health Concerns
☐ Beta Carotene Supplements	☐ Hormonal Issues
☐ Self-tanners	☐ Recurrent Skin Infection
☐ Fertility medication	☐ Hepatitis
☐ Bleaching Creams	☐ Abnormal Moles
☐ Retinoic Acid, AHA Creams	☐ Thyroid Disorders
☐ Acne medications (incl. Accutane)	☐ Eczema/Psoriasis
☐ Antibiotics	☐ Auto-immune Disorder
☐ Steroids/Prednisone/Topical Corticosteroids	☐ Fever Blisters/Cold Sores
☐ Glycolic Acid Products	☐ High Blood Pressure
☐ Immunosuppressant Medication	☐ Pregnancy or Nursing
☐ Blood Thinners or Anti-Coagulants (ie. Plavix)	☐ Cancer (past/present) Type: _____
☐ Vitamin K	☐ Pacemaker
☐ Aspirin	☐ Recent Surgery
☐ Fish Oils	☐ Disorders of the Blood
☐ Other: _____	☐ Keloid Scarring
	☐ Other: _____

I acknowledge that the above questions have been answered truthfully and to the best of my ability.

_____ Signature

_____ Date

PHOTO AND VIDEO CONSENT AND AUTHORIZATION

I understand that Integrative Naturopathic Medical Centre (the "Provider") is requesting my permission to use and disclose my name, photographs, audio and video recordings, or digital media for the following purposes: medical, client, and lay group education; seminars; lectures; webinars; public events; patient education materials, publications of any type; and marketing in any form or medium (which may include television, internet, and social media).

Please read each of the following statements carefully before signing this authorization:

1. I understand that this authorization is voluntary and being made at my request. I understand that if I do not sign this form, it will **not** affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that if I choose not to give this permission, or if I revoke my permission, I will still be able to receive any treatment or benefits that I am entitled to.
2. I understand that I will **not** be entitled to any payment or other form of remuneration as a result of any use of my name, photographs, audio and video recordings, or digital media.
3. I understand that by signing this authorization, I do **not** authorize the parties to use or disclose, any of my information pertaining to: (i) alcohol, drug, and/or substance use, diagnosis, or treatment; (ii) mental health diagnosis or treatment; or (iii) HIV/AIDS test results.
4. I understand that my name and any photographs, audio and video recordings, or digital media used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, in such case, will no longer be protected by applicable law.
5. I understand that all marketing materials that include my name, photographs, audio and video recordings, or digital media will remain Provider's property, solely and completely, and I waive all rights to such materials.
6. I understand that this authorization will be valid for ten (10) years from the date of signature unless I revoke the authorization in writing.
7. I hereby waive any right that I may have to inspect and/or approve the finished product or the copy that may be used in connection therewith, wherein my likeness appears, or the use to which it may be applied.
8. I understand that I may revoke this authorization **at any time** by sending Provider a written notification. I further understand that this revocation will be effective for future uses and disclosures of my name, photos or videos, but will **not** be effective for uses or disclosures that Provider has already made in accordance with this authorization.
9. I hereby release, discharge, and agree to indemnify and hold harmless the Provider and its agents from all claims, demands, and causes of action that I have or may have by reason of this authorization or use of my photographic portraits, pictures, digital images, audio or videotapes, including any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said images or videotapes, or in processing tending towards the completion of the finished product, including publication on the internet and social media, in brochures, or any other advertisements or promotional materials.

Please select one of the three options below:

I agree to the use and disclosure of my photos, and videos as described above.

I agree to the use of my photos /videos as described above but request that they are only shared within the clinic.

I deny the Provider's request to use and disclose my name, photos or videos as described above.

If you agree or deny the information presented in this authorization, please sign and date below:

_____ _____

Signature Date

MISSED APPOINTMENTS AND CANCELLATION POLICY FOR AESTHETICS

Your appointment time is reserved exclusively for you based on the type of treatment you would like to receive. If you are unable to attend, we require **2-business days' notice (Monday through Friday, excluding weekends and statutory holidays)** to avoid being charged for the time reserved. You can cancel via email to reception@integrative.ca or via phone during business hours at (604) 738-1012 Ext 1.

Patients are expected to fully understand the aesthetic service they are booking, including associated costs. It is your responsibility to be familiar with the details of the treatment prior to booking, as aesthetic missed appointment fees start at $75 per 30 minute treatment. If a significant amount of time has been reserved with your practitioner, the missed appointment fee may reflect the cost of the time lost.

Fees will be charged to the credit card on file, and a receipt will be emailed to you for your records.
We recognize that unexpected situations arise; however, to maintain fairness for all clients, cancellation fees will only be waived in the case of a medical emergency requiring immediate treatment, a death in the family, or a natural disaster.

While we offer appointment reminders by text or email as a courtesy, we cannot be held responsible for any technical issues that may prevent the reminder from reaching you. It is ultimately each patient's responsibility to track and attend appointments as scheduled.

While our Aesthetic treatments are performed by Naturopathic Doctors, aesthetic services are unavailable for submission to extended health providers and patients will be required to pay out of pocket for these treatments in-clinic.

Acknowledgement and Consent

By booking an appointment, you acknowledge and agree to this policy and accept the consequences of any missed or late-canceled appointments as outlined.

_____ _____

Signature Date