K-W HOMEOPATHIC MEDICINE AND WELLNESS CLINIC

751 King Street West, Suite 310
Kitchener, ON N2G 1E5

T (519) 603-0505 F (519) 603-0506

INFORMED CONSENT

for Homeopathic Assessment and Treatment

Patient Name _____ File No. _____

Registrant Name _____Irene Schwens_____ CHO Registration # ___15241____

ASSESSMENT and RECOMMENDED TREATMENT
(including those by referral to another practitioner)

_____

_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the assessment and recommended treatment described above and have discussed to my satisfaction this and any requests of related information with the Homeopath named above. I have been given the opportunity to ask questions about the assessment and recommended treatment and have received answers to such questions. I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, material risks, material side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

I confirm that the decision to seek homeopathic treatment is solely my decision. I further confirm that the homeopath has represented to me that any treatment provided is in no way intended to be an alternative treatment to what is or may be recommended by a physician. Furthermore, I acknowledge that I am encouraged to pursue all recommendations of my physician for treatment.

I understand the cost of treatment and agree to pay my account according to the guidelines set by K-W Homeopathic Medicine and Wellness Clinic. I also understand that all fees are non-refundable.

All information disclosed is confidential and remains within the premises of K-W Homeopathic Medicine and Wellness Clinic.

As a result, I do hereby voluntarily provide my informed consent for the recommended treatment specified above.

Dated and signed this _____(day) of _____(month)_____(year)

Patient or Lawful Representative Signature _____

Witness signature* _____

Relation to Patient _____

Address _____

_____

Telephone No. _____

*Witness signature is advised but not required

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REFUSAL OF CONSENT

I understand that I can withdraw my refusal of consent

I also understand that my refusal of the above consent is contrary to the recommendations of my Homeopath. As a result, I do hereby voluntarily and on an informed basis refuse consent for the recommended procedure(s) specified above.

Patient or Lawful Representative Signature _____ Date signed _____

Witness signature* _____

Relation to Patient _____

Address _____

_____

Telephone No. _____

Treatment	Cost
Initial Constitutional Consultation	
• Standard (up to 2 hours)	$ 200.00
• Extended (3 hours)	$ 300.00
Follow-up Visit	
• 30 minutes	$ 65.00
• 1 hour	$ 90.00
Acute Consultation (30 min)	$ 65.00
Short Consultation (10 min)	$ 25.00
Telephone Consultation (15min)	$ 35.00
Nutritional Analysis	$ 90.00
Bach Flower Consultation	$ 60.00

* All prices to be understood HST extra.

Remedies are charged at **$ 8.00** resp. **$ 12.00** (rare remedies) each. Personal Bach Flower compositions are **$ 15.00** each. Postage is charged extra when a remedy is mailed to a patient.

Cancellations

48 hours notice is required for cancellations. A late cancellation fee of half of the amount of the session will apply. In case of emergency cancellations after hours please call 519-603-0505 and leave a message.