NOTTAWASAGA Family Health CENTRE

Office Policies & Expectations

We are pleased to welcome you to the Nottawasaga Family Health Centre with Dr. Furtado and Dr. Dawson. Our team looks forward to getting to know you better in the coming months and years. To make sure that you know what to expect from us, we have put together the following office policies. Please let us know if you have any questions or concerns, we will be happy to discuss them with you.

MUTUAL COURTESY AND RESPECT

This is our most important policy! We promise you that our team of professionals will always treat you with courtesy and respect. In order to work well with you, we expect the same politeness and respect in return. We understand that, at times, you may disagree with our team or have frustrations that we need to address together. We promise that we will always be willing to discuss your concerns in a conversation of mutual respect.

However, we must be clear that **ANY** abusive or aggressive (verbal or physical) behaviour toward any of our staff will result in **immediate removal** from our practice. This includes any form of cyber-bullying or online smearing.

I have read and understood the policy on Mutual Courtesy and Respect:

_____ _____

Signature Date

APPOINTMENTS

- Booked by phone, in person or by e-mail. No walk-in appointments.
- Please tell our staff why you are booking the appointment so they can make sure you have enough time with the doctor.
- Regular appointments are 15 minutes and are timed to discuss ONE medical issue with one patient. If you have multiple issues, or need an appointment for a family member, please book a separate appointment.
- Appointments for physicals are 30 minutes.
- You must present a valid OHIP card at each visit – failure to present your OHIP card may result in a charge for your appointment and/or your appointment will be cancelled and rescheduled.

We do not offer reminder calls for your appointments.
Attending on time, on the correct date is your responsibility.

- 48 hours notice is required for cancelled appointments,
- There is a $25 fee for missed appointments, without proper notice.
- 3 no-show appointments or late cancellations is grounds for termination.

OPIOIDS AND SEDATIVE MEDICATIONS

Because we are committed to your health and well-being, it is important that you clearly understand our policy and expectations regarding opioids and sedative medications. During our careers in Emergency Medicine, Dr. Dawson and Dr. Furtado have witnessed far too many tragedies caused by these medications. Therefore, to ensure your health:

Our opioid and sedative medication practice is EXTREMELY conservative.

- Patients who are currently prescribed chronic opioids (outside of end of life situations) must **sign a opioid contract** and **deliver random urine drug screens**, both of which will be done at your initial appointment.
- We do **NOT prescribe doses of opioids in excess of Canadian guidelines.**
- Patients currently on higher doses MUST be willing to work with the physician to either taper down on doses or be switched to less dangerous medications.
- Patients prescribed any opioid medications must be seen by your physician at least three times a year to ensure appropriateness of medication.
- We will NOT sign off on early releases of controlled medications.
- To support you in managing chronic pain, we offer referral to pain management clinics.

I have read and understood the policy on opioid and sedative medication:

_____ _____

Signature Date

URGENT CARE

Dr. Dawson and Dr. Furtado are experienced emergency physicians. However, our clinic is not the place for dealing with true medical emergencies, as we do not have the proper equipment to treat you safely.

- Visit the EMERGENCY DEPARTMENT If you have chest heaviness, significant shortness of breath, severe abdominal pain, uncontrolled bleeding, stroke symptoms, or concerns about fractured bones.
- If you aren't sure whether a medical issue is an emergency **after hours**, please use TELEHEALTH.
- Our office will try to accommodate if an **urgent**, but not immediately life or limb threatening medical issue arises.

When possible, we encourage our patients to avoid using walk in clinics as they do not have your medical history, and we often do not receive reports of your visit.

NOTTAWASAGA Family Health CENTRE

Policies & Expectations

PRESCRIPTION POLICIES

- Continued medication renewals may be submitted by your pharmacy to our office. Please allow **5 business days** for each renewal.
- We may need to see you before issuing the renewal, our office will contact you if we need to see you.
- Prescriptions for massage therapy, physiotherapy and orthotics can be done if recommended for your care from your physician.

Multiple phone calls or emails about the SAME refill is disruptive to our staff, please call only ONCE per refill.

FORMS

- Form completion is not covered by OHIP. Fees will be based on the number of pages filled out, in line with the Ontario Medical Association recommendations
- Forms may be brought to office prior to your appointment for review and an exact quote.
- Form completion requires a separate booked appointment and cannot be combined with any other medical issues you wish to discuss.
- We will need all relevant prior medical records on file to complete your form accurately.

SERVICES NOT COVERED BY OHIP

- Missed appointments (less than 48 hours' notice): $40
- Sick notes (payable when picking up note): $20
- Form completion: ..... usually between $40-$160
- Additional uninsured service price list is posted at the office, and you will be advised of any fee when the service is booked.

All fees are payable before service

CONFIRMATION OF POLICY REVIEW

I have read and understood the Nottawasaga Family Health Centre's Policies & Expectations:

_____ _____

Signature Date

Please update your address, phone number and email address with our office as soon as any changes occur.

NOTTAWASAGA Family Health CENTRE

Basic Patient Information Form

This will be used to begin the process of registration, once we have booked an initial appointment – we will require further information including medications and medical history to have it inputted in your chart – for now we will just be using this information to contact you to set up initial appointment and prepare our system with your name. *Please note we will be using Health Care Connect directly for patients to ensure we take on patients without a physician and are in highest need of a physician first.*

FULL NAME (FIRST, MIDDLE, LAST)	
DATE OF BIRTH:	
ADDRESS: (Street address, City, Postal Code)	
HEALTH CARD NUMBER (include version code and expiry date)	
PHONE NUMBER: (Home and Cell) DO you prefer call or text?	
EMAIL ADDRESS: (by adding this you agree to communication on occasion through email)	
DO YOU HAVE A PHYSICIAN CURRENTLY? (yes or no)	
ARE YOU REGISTERED WITH HEALTH CARE CONNECT? (yes or no)	

Nottawasaga Family Health Centre

To provide the best possible care for our patients, we need your most accurate and up-to-date medical information. This information allows us to create plans of care that will suit your unique needs.

*Where appropriate please indicate "**unknown**" or "**not applicable**." Do not leave any sections blank. Incomplete or blank forms will **NOT** be contacted for an intake appointment with a physician.*

I am applying to be a patient of: Dr. V. Dawson ☐ Dr. R. Furtado ☐

Patient Medical History and Information

First Name:		Last Name:
Date of Birth:	Age:	Health Card #:
Address:		Home Phone:
Town:		Cell Phone:
Postal Code:		E-mail Address:
Next of Kin:		Relationship:
Contact for Next of Kin:		

Preferred Pharmacy:	In Which Town?

Where do you live now? Home ☐	Retirement Home ☐	Nursing Home ☐
If you reside at home, who lives with you?		
Relationship:		

Do you smoke? yes no	If yes, **now or in the past**, how many years?	If yes, how many packs per day (on average) have you smoked over the years?
Do you use alcohol? yes no		If yes, how many drinks per week on average?
Do you use recreational drugs? yes no		If yes, what do use?

Special diet? yes no	Type of diet?
How many hours of exercise per week?	Type of exercise?

Medication: Please list **all** prescription drugs you are taking	**No medication** ☐
1	6
2	7
3	8
4	9
5	10

f you are taking prescription medications, please have your pharmacy fax a complete list of your medications to 705-717-756

Your appointment WILL NOT be booked until we receive the FAXED list from your pharmacy.

Allergies: Please state any allergies you have and type of reaction	**No allergies** ☐
1	
2	
3	
4	
Do you have an I.V. dye allergy? yes no unsure	

If you require additional space to answer these questions, please continue on a blank sheet and attach it to this form.

Nottawasaga Family Health Centre

Surgeries: Please list all surgical procedures or hospital admissions of greater than one day		**No surgeries or admissions** ☐	
Procedure	Year	Procedure	Year
1		6	
2		7	
3		8	
4		9	
5		10	

Medical Conditions: Please **tick** each condition you have							
Hypertension	☐	**Chemotherapy**	☐	**Sexually Transmitted Illness**	☐		
Diabetes	☐	**Radiation Therapy**	☐	**Chronic Pain**	☐	Where?	
Heart Disease	☐	**Dentures**	☐	**Glaucoma**	☐	right eye	left eye
Coronary Stents	☐	**Diverticulosis**	☐	**Cataract**	☐	right eye	left eye
Emphysema	☐	**Dementia**	☐	**Deafness**	☐	right ear	left ear
Asthma	☐	**Thyroid Disease**	☐	**Hearing Aids**	☐	single	both
Cancer	☐	**Suicidal Feelings**	☐	**Dialysis**	☐	yes	no

List any skin disease or rash:	List any mental disorders, depession, anxiety:

	Date	**Results**				**Date**	**Results**		
Colonoscopy		abnormal?	yes	no	**Mammogram**		abnormal?	yes	no
Stool (occult blood)		abnormal?	yes	no	**Bone Density Scan**		abnormal?	yes	no
Pap Test		abnormal?	yes	no	**Opthalmic/Eye exam**				

Family History: Please be as specific as possible (example: "uncle with lung cancer" **NOT "**cancer on mother's side")

Adult Immunizations: Please tick each immunization you have had and indicate the year received					
	Year	Details		Year	Details
Tetanus	☐		Shingles	☐	
Pneumonia: Prevnar-13	☐		COVID-19	☐	
Pneumonia: Pneumovax	☐		Flu Shot	☐	

Child Immunizations: Please bring your child's immunization booklet to the office

By signing this form, you declare that all the information is accurate and true to the best of your knowledge. You also acknowledge that failure to complete this form accurately, by providing **intentionally false information** and/or **omitting previous diagnoses** and/or **omitting medications**, will result in non-acceptance to the practice.

signature of applicant or parent/guardian

date signed

Ontario

Ministry of Health
and Long-Term Care

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (l), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218–9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

PG07799

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

PHYSICIAN COPY

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

Consent to Release Personal Health Information

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry *(see box below);*
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario);*
c) the Patient Enrolment Model to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor; or
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above);*
b) my family doctor leaves this Patient Enrolment Model;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Model to which my family doctor belongs regularly provides services.

Contact Information:

Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9

Call: INFOline 1 888 218–9929
TTY 1 800 387–5559

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)