FILE COPY

DR. SABRINA GIUSTRA, N.D.
DOCTOR OF NATUROPATHIC MEDICINE
ACKNOWLEDGMENT AND INFORMED CONSENT

I_____
(Patien t's Name)
hereby acknowledge and confirm that prior to signing this document and prior to undergoing any treatment:

I. I have been informed by you and understand that any treatment or advice provided to me as a patient of Dr. Giustra, N.D., Doctor of Naturopathic Medicine is not provided in the place of or to the exclusion of any other treatment or advice that I may now be receiving or may in the future receive from a physician, surgeon, or any other licensed health care provider (such other treatment collectively referred to as "Conventional Medical Treatment");

II. I have been informed by you and understand that I am at liberty to seek or continue to seek Conventional Medical Treatment and to consult with a physician, surgeon or any other licensed health care provider in order that I can make an informed decision as to whether at any given time or times it would be in my best interests to obtain Conventional Medical Treatment;

III. No Naturopathic practitioner(s), employee(s), agent(s) or any other person (s) directly or indirectly employed by or associated with Dr. Sabrina Giustra, N.D. have suggested or recommended to me that I refrain from and/or discontinue seeking Conventional Medical Treatment;

IV. I have been informed by you and understand that the treatment and products that are rendered, recommended or supplied by Dr. Sabrina Giustra, N.D. may be different from the treatment and products that are rendered, recommended or supplied in Conventional Medical Treatment;

V. I have been informed by you and understand that the Naturopathic Treatment and Products provided by Dr. Sabrina Giustra, N.D. are not covered under the Ontario Health Insurance Plan (OHIP) and accordingly, I hereby agree to pay my account to Dr. Sabrina Giustra, N.D. at the conclusion of each and every visit for naturopathic services and products. Once a product is opened, I acknowledge that I cannot return it for a refund. I further acknowledge and agree that I will be charged the full fee for all and any missed appointments, unless I have advised Dr. Sabrina Giustra, B.Sc., N.D. of my cancellation no less than twenty-four (24) hours in advance of the scheduled appointment;

VI. You have explained to me and I understand the nature of Naturopathic Treatment and Products that you will be providing to me. You have advised me of and understand the potential side effects that may be associated with certain Naturopathic Treatment and Products. You have also urged and encouraged me to ask such questions as I may have at any time and to advise you immediately if I either wish to discontinue or should decide not to undergo any specified type(s) of treatment(s);

VII. I am not an agent of any private, local, country, provincial or federal agency attempting to gather information without stating my intention to do so;

VIII. I give consent to Dr. Sabrina Giustra, N.D., and/or her staff to collect information from myself that is relevant to my health in the scope of Naturopathic Medicine, I give consent for Dr. Sabrina Giustra, N.D. and/or her staff to contact me in regards to appointment time changes, reminders, payments, follow-up visits, phone consultations or other concerns regarding my Naturopathic Care. No information will be released or obtained to or from anyone other than the undersigned unless written consent is obtained by the undersigned (Exceptions to this may include imminent danger to self, other, or minors). The undersigned is entitled to obtain a copy of their Naturopathic file (a fee may be charged). All information relevant to your Naturopathic care will be held in the strictest of confidence. A copy of Dr. Sabrina Giustra, N.D.'s privacy policy can be made available upon request.

I am at least sixteen (16) years old and I have read and am in agreement with the foregoing statements and have had the opportunity to discuss the same with Dr. Sabrina Giustra, N.D. I hereby authorize and consent to such treatment by Dr. Sabrina Giustra, B.Sc., N.D. as she considers necessary or desirable, subject to any additional instructions or modifications that I may provide/authorize from time to time.

OR

I am the _____ of the patient who is under the age of sixteen
(Relationship)

years, I confirm that I am legally authorized to grant consent to have the patient treated by Dr. Sabrina Giustra, B.Sc., N.D. I have read and am in agreement with the foregoing statements and have had the opportunity to discuss the same with Dr. Sabrina Giustra, N.D. as she considers necessary or desirable, subject to any additional instructions or modifications that I may provide/authorize from time to time.

_____ ____ _____ _____
Witness Signature of Patient or Legal Guardian Date