Patient Name : ______________________ File No. : ____________

Homeopath Name : RIKENKUMAR GAJJAR Certification No.: OHA 2013-07

Homeopathy is a holistic system of drug therapeutics based on the principle of 'similia similibus curantur' which means 'like cures like', also known as 'law of similars'. It states that since exposure to a substance in a large dose can cause specific symptoms in a healthy person, that substance when correctly prescribed as a homeopathic remedy in a smaller dose can stimulate the body's internal curative powers to overcome similar symptoms in illness. Homeopathy utilizes plant, animal or minerals as original medicinal substance to prepare a homeopathic remedy by diluting the original medicinal substance in a series of pharmaceutical processes as per the principle of drug dynamisation. Such pharmaceutical processes not only minimize the risk of medicinal side effects, but also release the full effectiveness of the original medicinal substance. Homeopathic medicines are available as globules, granules, tablets, dilutions, gels, syrups and suppositories. They also contain non-medicinal ingredients like cane sugar, lactose, water and alcohol.

Furthermore, Homeopathy offers an individualized approach to your health. It does not merely focus the illness in isolation, but focuses the individual who presents with the illness. Thus, Homeopathy considers the total response of the individual to the unfavorable environmental factors. This is manifested as signs and symptoms on physical, emotional and intellectual plane of the patient. The objective of homeopathic assessment is to consider a complete and accurate picture of the patient through perceptible signs and symptoms. Hence, homeopath will interrogate upon various subjective and objective findings to collect detailed information regarding health status of the patient.

I understand that subjective findings regarding my health status will be collected by interrogating about;

- ✓ personal account of chief complaints and other symptoms
- ✓ personal health status
- ✓ emotional and intellectual state
- ✓ lifestyle and diet habits
- ✓ various past experiences and the effects on quality of life
- ✓ various past illnesses and the effects on quality of life
- ✓ use of other supplements and pharmaceuticals
- ✓ health status of my family members

I further understand that objective data regarding my health status will be collected by various observations and clinical findings from;

- ✓ physical examination
- ✓ medical tests
- ✓ diagnostic or laboratory result reports
- ✓ family members and caregiver
- ✓ another healthcare provider from my circle of care
- ✓ homeopath about my non-verbal communication, gestures, gait etc…

I acknowledge that collection of my demographic information like age, gender, date and place of birth, developmental state, culture, ability, education and occupation is often a part of the patient intake process.

I understand that all information collected as a part of the patient intake process and homeopathic assessment, will be accurately and concisely recorded on paper or electronically on computer as a patient record. I further understand that a timely and chronological patient record will contain a patient chart, appointment book and financial records. I acknowledge that a patient chart will have signed informed consent, duly filled initial intake form, essential chronicle of the history of my medical records and a guide for the direction of future care. I further acknowledge that confidential information on my medical records and health history will be kept safe and secure in the office of said healthcare facility. I understand that all my personal health information is confidential, and confidentiality is essential for establishing and preserving trust in the patient- practitioner relationship. I acknowledge that my personal health information will not be released to any individual without my consent or when it is required by law or permitted under legislation. I understand that no one other than authorized health professionals in my circle of care would have access to my personal health information. I confirmed that I may have access to the copy of my personal health information.

I understand that collected information will be used;

- ✓ to provide effective, progressive and organized care
- ✓ to construct an image of the disease and totality of the symptoms
- ✓ for case analysis and repertorization
- ✓ to arrive at homeopathic diagnosis
- ✓ to select suitable medicine or sequence of medicines
- ✓ to determine case specific potency and posology
- ✓ to select appropriate delivery mechanism of medicine
- ✓ to communicate individualized treatment plan
- ✓ for follow-up and case management
- ✓ to promote patient-specific healthy lifestyle choices
- ✓ to optimize treatment outcome
- ✓ to recommend referral and/or collaborate with other health care provider
- ✓ to provide continuity of services if the care of the patient is transferred to another practitioner for any reason

Homeopathy is considered to be a safe integrative and preventative system of health care provided it is used correctly under the supervision of a homeopath. However, like other gentlest forms of treatment, homeopathic treatment also has potential risks and side effects. The risks associated with homeopathic treatment include, but are not limited to; aggravation of pre-existing symptoms, a relapse of symptoms, temporary increase in the intensity of symptoms and the temporary development of new symptoms until more permanent relief attained. I acknowledge that homeopathy is not intended to be a substitute for conventional and traditional medicine. I further acknowledge that I have the option of seeking or continuing conventional medical care from a medical doctor and that homeopathic treatment and conventional medical treatments are different but can complement each other. I understand that there has been no suggestion made to me that I refrain from selecting or following conventional

medical treatment. I acknowledge that the therapy and information offered should not be construed as a medical diagnosis of any medical disease or injury.

I understand that the initial consultation may last for 90 to 120 minutes and a regular follow-up may last for 30 to 45 minutes. I further understand that a block of time has been set aside for my private appointment. I acknowledge that a 24 hour notification is required if I want to change or cancel the appointment. I further acknowledge that there is a full charge for appointments changed or canceled less than 24 hours in advance. I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment. I acknowledge that phone consultations or consultations by video conference will be billed at the usual hourly rate. I understand that regular follow-up could be scheduled at every 4 weeks. However, frequency of visit would entirely depend upon the recommended treatment plan. I understand that fees for services and products would be charged separately. I understand that current fees for services are as follows.

- ✓ Initial consultation: $150
- ✓ Second consultation: $100
- ✓ Regular follow-up: $75

I acknowledge that I have been informed of and understand the basic homeopathic principles and process, homeopathic assessment, nature and safety of homeopathic medicine, risks and benefits of homeopathic treatment, duration and frequency of homeopathic visits, fee structure, specified recommended treatment and treatment expectations. I have been given the opportunity to ask questions about the homeopathic assessment and recommended treatment and have received satisfactory answers to such questions. I further acknowledge that I have been informed of and understand the consequences of not having the procedure(s) and what alternative course(s) of action are available to me. I understand that I have a right to withdraw my consent at any time.

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

Signature of patient/ lawful representative/ substitute decision maker: ______________________

Date: ______________________ Day: ______________________ Location: ______________________

Signature of witness*: ______________________ Relation to patient: ______________________

Address: Line 1: ________________________________________________

Line 2: ________________________________________________

City/town: ______________ Province: ______________ Postal code: ____________

*Signature of witness is advised but not required.



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