



Dr. Sara Korsunsky BSc., N.D. #2-40 Centre St. Gimli, MB, R0C 1B0 (204) 642-4842 www.sunskywellness.com

Welcome to our Office

We want you to enjoy and benefit from your visits with us.

Your first 1-2 Naturopathic visits will consist of **consultation, detailed history, a general physical exam and a more specific naturopathic examination.** Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests through your medical doctor, or additional testing through our office lab facilities. Through this healthcare assessment, we are able to establish a baseline measure of health that we can then use to monitor your progress.

On your second visit, **a report of findings and an in-depth treatment plan** will be explained to you. Programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, and traditional Chinese medicine.** Your program will also involve **lifestyle recommendations** that are logical and sensible. We encourage you to have a support team as you make these changes. Often having someone else, (a partner, family member or friend) undergoing naturopathic care at the same time will help to ease you both toward better health. This return visit is also a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call our office.

On your following visits, your progress will be monitored and treatments will be modified accordingly. Follow up visits are usually two to four weeks after your initial visit. If you are receiving acupuncture treatments visits will be more frequent, either once or twice weekly for 6-10 sessions. As you start to experience a new level of wellness, we suggest an office visit every three to four months for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Your booked appointment is reserved for you. We request that if you are unable to keep a scheduled appointment, you give our office a minimum of 24 hours notice. We are then able to provide that appointment time to someone on our waiting list. **If we do not receive sufficient notice, you will be charged for the missed visit as per industry standard with health professionals.**

Extended healthcare offers coverage for Naturopathic consultations, while Naturopathic medicines and lab tests are not usually covered; please inquire with your HR department. Payments are due at the time of the appointment.

Effective Sept. 1, 2008 Naturopathic Medical fees are:

(GST will be added to all fees)

Dr. Sara Korsunsky ND

Initial adult visit	60 min	\$110	Pediatric follow up visit	30 min	\$55
2 nd visit	45 min	\$82.50	Acupuncture initial visit	60 min	\$90
Follow up visit	30 min	\$55	Acupuncture follow up	40 min	\$55
Pediatric initial visit	60 min	\$100	Cosmetic Acupuncture	12 x 60 min.	\$1200

We maintain a dispensary of professional quality nutritional supplements, botanicals and homeopathics for the treatment of our patients. Items are individually priced and GST & PST is added.

We accept the following methods of payment:
Visa, Mastercard, Debit Card, or Cash

If you have any concerns, please contact our front desk staff who will happily pass on your message to Dr. Korsunsky.

Please fill out the following forms (Page 2-4) and bring to your first appointment along with the additional forms for your age (adult, adolescent, pediatric).

Naturopathic Patient Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to remind you of your upcoming visit and inform you of our office events and news and will not be distributed for any other use.

First Name _____ Last Name _____
 Address _____
 City _____ Province _____ Postal Code _____
 Telephone (H) _____ (W) _____ (F) _____
 E-mail _____ Cell _____
 Emergency Contact _____
(Full name) (Relation) (Telephone)

**I have read Welcome to our Naturopathic Office provided with this form.
 I am aware of the type of treatments offered and I agree to abide by the office policies.**

Signature _____ **Date** _____

Occupation _____ Employer _____
 Past Occupations _____
 Date of Birth _____ Age _____ Sex M F Marital status _____
 Number of children & their ages _____
 Blood Type _____ Height _____ Weight _____ Ideal Weight _____
 Religion or personal philosophy _____
 Name of Medical Doctor _____ Telephone (_____) _____
 Date of last physical _____ Date of last lab tests _____
 Have you been treated by a Naturopathic Doctor? Other health practitioners?
 Name _____ Name _____
 When? _____ When? _____
 How did you hear about our clinic? _____

Please list (in order of importance) your primary health concerns / reasons for your visit.	Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments.

Please turn over ⇒

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Please leave this space blank. It will be cut off.

Please list all **pharmaceutical medications, herbals, vitamins and supplements** (& dosages, if known)

Now	In the Past

Please list any **allergies** you have and what kind of **reaction** occurs.

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Please list all **hospitalizations, fractures or major illnesses** that you have had.

Type of illness, operation / procedure Date Any ongoing concerns?

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How would you rate your **energy level**? _____ (from 1-10, **10 being highest**) Do you wake-up feeling refreshed? Y___ If N___ What time do you sleep from and wake up at? _____

How many glasses of **water** & of what **kind** do you drink per day? Please indicate below.

Tap_____ Filtered_____ Distilled_____ Reverse Osmosis_____ Spring_____

How many **cups / day** do you drink of each the following?

Herbal Tea _____ Black Tea _____ Coffee _____ Do you add milk/cream? _____ Sugar? _____

Do you **smoke**? Y ___ # cigarettes / cigars per day _____ How many years? ___ In the past? Y ___ Quit when _____

Do you drink **alcohol**? Y___ Type & # of drinks per week _____ In the past but quit? Y _____

Do you use **recreational drugs**? Y ___ In the past? Y ___ What kind and how often? _____

Do you **exercise**? N___ Y___ Hours per week _____ Type of exercise _____

Do you watch **TV**? N___ Y___ # of hours per week _____

Please check all the **childhood illnesses** you have had.

<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Asthma

Have you been **vaccinated**? N___ Y___ Did you have any adverse reactions? _____

What vaccines have you had recently? _____

Please check all of the following **conditions** that are applicable to **you & your family** and note who.

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Gout	<input type="checkbox"/>
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart murmurs	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	Auto Immune	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>
<input type="checkbox"/>	Crohn's or Colitis	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Stroke or aneurysm	<input type="checkbox"/>
<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
<input type="checkbox"/>	GERD/hiatal hernia	<input type="checkbox"/>	Other	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma / Cataracts	<input type="checkbox"/>		<input type="checkbox"/>

***On the reverse side of this form, please record everything that you ate yesterday for breakfast, lunch, dinner, snacks and beverages in as much detail as possible.**

Please leave this space blank. It will be cut off.

Cancellation/ Tardiness Policy

The following policy applies to all cancelled & missed appointments with Dr. Sara Korsunsky, ND:

- Due to the length of Dr. Korsunsky's visits, a cancellation and tardiness policy is in effect as per industry standards. This policy is a 2-way policy of consideration of both Dr. Korsunsky's time as well as your time. Your time with the doctor is reserved for you in advance and you will be charged for the length of your time spent with her (appointment lengths are 1 hour, 45, 30 or 15 mins). Please remember this policy and feel free to call to confirm your appointment time and length. We will do our best to remind you of your visit but it is ultimately your responsibility to arrive on time.
- Patients must give a minimum 24 hours notice for cancellations or changes to appointments or a fee of \$55 will be charged. This cancellation fee applies to missed appointments as well.
- Patients will be invoiced for missed or cancelled appointments and payment is due within one week. Fees will be applied to the credit card provided if not paid within one week of missed appointment.
- For patients who miss initial visits and wish to rebook, payment must be made in advance upon rescheduling in person. Payments by credit card cannot be accepted over the telephone.
- Patients will be forgiven for 1 missed appointment due to illness and conditionally based on reasonable emergency situations. The clinic staff will telephone following missed appointments and transmit the reason to Dr. Korsunsky. Application of the cancellation fee is at the discretion of Dr. Korsunsky, not the clinic staff.
- Patients who are more than 15 minutes late will be charged the full fee of the length of their originally scheduled visit.
- Please keep a copy of this policy with your medical files to avoid misunderstandings.

Thank you for your cooperation.

INFORMED CONSENT (ADULT)

Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and energetic aspects of an individual. Your naturopathic doctor will conduct a thorough case history, physical exam and may request specific blood and/or urinary laboratory reports to be used as part of the treatment work-up.

It is very important that you inform your naturopathic doctor immediately of all disease process that you may be experiencing, and of any medication, over the counter drugs or supplements you are taking. If you are pregnant, suspect you are pregnant or are breast-feeding, please advise your naturopathic doctor.

Statement of Acknowledgement

As a patient of this office, I have read the information about the health care to be provided and understand it is based on naturopathic and other supportive principles and practices.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to anyone other than Dr. Korsunsky unless so directed by myself or unless law requires it. With your permission, I may also discuss pertinent details of your case with another practitioner in the Inglewood Family Health Centre in order to make a referral. I will inform the naturopathic doctor if I have any concerns about these methods of enhancing my care in. I understand that I may look at my medical records at any time and can request a copy of it by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in very young children, or for those on multiple medications. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy, and all medications including over the counter drugs and supplements.

The slight health risks of some Naturopathic treatments include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or acupuncture needles
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of my naturopathic treatment at this office. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and to discontinue participation in these procedures at any time. I accept full responsibility for any fees incurred during care and treatment and for missed appointments without 24 hours advance cancellation or emergent circumstances as per the cancellation policy that I have read.

By signing below and providing your credit card number, you acknowledge having read the cancellation/tardiness policy in full and your cooperation with this policy.

NAME of PATIENT (Please Print) _____

DATE _____ SIGNATURE _____

CREDIT CARD #: _____ EXP DATE: _____

Thank you for your cooperation!