ABSOLUTE MEDICAL CENTRE

60 Main St. East, Grimsby, Ontario, L3M 1N1 • Phone: (289) 235-7700 • Fax: (289) 235-7451

SPEECH-LANGUAGE PATHOLOGY – Kim Smith, SLP

Voice, Swallowing, Chronic Cough, Upper Airway Disorders

Registration Form:

Patient's Full Name (as shown on Health Card): _____

Guardian name (if applicable): _____ **DOB**: _____

Address: _____ **City**: _____ **Prov.**: _____ **Postal Code:** _____

Telephone: _____ **Email (for appointment reminders)**: _____

Referring Physician's Name and phone number: _____

Reason for Referral/Primary Concern:

_____

_____

Relevant Medical History and/or Test Results:

_____

_____

List of Current Medications (may also be scanned by administration if provided):

_____

_____

Please initial the following:

_____ I consent to receiving text message/emails regarding appointment reminders, billing enquiries and communication regarding your personal health information.

_____ I consent to use of virtual platforms (e.g. Zoom video conferencing) and/or telephone for discussion of medical information and understand that these are not secure platforms that are PHIPA compliant. **Every effort will be made to ensure virtual appointments are as secure as possible with individual links that are password protected; however, we are not liable for any breach of patient confidential information as a direct result of use of these platforms.*

_____ I consent to use of audio tools to facilitate efficient and prompt documentation of encounters and communication with referring provider.

_____ I provide consent to photographs/videos, if deemed necessary, by the health care team to be saved in patient chart* (**No part of video or photograph will be shared with any other provider not involved in circle of care without patients' explicit consent).*

_____ I consent to use of non-secure email for certain sharing of information, such as patient information handouts, online hyperlinks or videos, for sharing at the request of my doctor. Patient-specific forms or information may only be shared by email if I have given consent explicitly for that purpose to the clinician prior to sharing of information (e.g. diagnostic letters or requisitions sent by email).

_____ I agree with no harassment policy of Absolute Medical Centre and agree to comply with maintaining respectful and safe environment of all parties involved. Any concerns regarding hostile behaviour will be a ground for termination of doctor patient relationship.

_____ I am aware that a no-show fee ($100) may be applied if there are reoccurring missed appointments. Please provide 24-48 hours notice if you cannot attend an appointment.

_____ I am aware I can rescind consent for any of the above but need to notify the clinician and office administration of this as soon as possible.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Date: _____

PATIENTS MAY SELF-REFER (PHYSICIAN REFERRAL IS NOT REQUIRED). PLEASE BRING THIS FORM AND ANY RELEVANT TEST RESULTS/HISTORY WITH YOU TO YOUR FIRST APPOINTMENT OR ASK YOUR DOCTOR TO FAX THEM AHEAD OF TIME.