INITIO

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CT NON-CONTRAST INTAKE FORM

Personal Information

Height: Weight:

Last Name: First Name: Middle Initial: DOB (mm/dd/yyyy):

Diabetes:

☐ Check here *if you are diabetic* and complete the section directly below. If you are not diabetic, skip this section.

Fasting blood glucose: (mmol/L)

Are you on the following medications: ☐ Insulin ☐ Diabetic oral pill (e.g. metformin)
(If Yes, please indicate the name and time last taken)

Female Patients:

☐ Pregnant Date of last menstrual period:

All Patients:

DATE & TIME OF NEXT APPOINTMENT: TIME OF LAST FOOD & DRINK (EXCEPT WATER):

Medical History

General:

All patients, please complete this section. Please **check all relevant boxes to indicate "Yes"** and provide detail below. Leave blank if not applicable.

☐ Do you have any allergies?	☐ Are you claustrophobic?	☐ Are you mobile?
☐ Need special help?	☐ Are you aware of the NO LIFT policy?	☐ Do we need to take any infectious precautions?
☐ Do you have any infection or inflammation?	☐ Are you on antibiotics?	☐ Any heart abnormalities?
☐ Any recent serious injuries? (e.g. broken bones)	☐ Do you have asthma?	☐ Any blood disorders?
☐ Any complaints of pain?	☐ Any foreign bodies? (e.g. pacemaker)	☐ Have you ever been diagnosed with cancer?
☐ Are you currently taking any medications?	Please specify:	

Have you had any recent medical imaging done?	Indicate where and when if applicable.	
☐ PET/CT	☐ CT	☐ MRI
☐ Nuclear Medicine	☐ Barium studies	☐ Other

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Have you had any recent treatments? If yes, provide details below.

☐ Chemotherapy ☐ Radiation therapy ☐ Biopsy

☐ Surgery ☐ Other (e.g. naturopath)

Referrals:

Family Doctor: Referring Physician: ☐ Same as Family Doctor Nurse Practitioner (if applicable):

How did you hear about our clinic?

☐ Website ☐ Doctor Referral ☐ Promotion / Events

☐ Social Media ☐ Search Engine ☐ Family / Friend

☐ Check here if all the information in this section has not changed since provided to INITIO Medical Group Inc. Please proceed to next section.

Emergency Contact Person: Relationship: Primary Phone #:

IMPORTANT:

All or a portion of the information contained in this document may have been transcribed by an employee or contractor of INITIO Medical Group Inc. The information may have been obtained from the patient signing this form through an over the phone screening process. By signing below, I am verifying that the information contained in this document is accurate and correct.

Signature: _____ Date: _____

If someone helped you verify/translate this form, fill out the section below:

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

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INITIO MEDICAL GROUP INC – INFORMED CONSENT

Use of Personal Information

INITIO Medical Group Inc. (INITIO) collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. If you have any questions, please contact the INITIO Health Privacy Officer at info@initiomedical.ca. We use and disclose your personal information in the following ways:

- To assess your health concerns, advise you of options and provide healthcare.
- To communicate with other treating healthcare providers, including your physician.
- To obtain diagnostic test results pertinent to the condition for which you are seeking treatment.
- To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail.
- To establish and maintain contact with you.
- To collect unpaid accounts and process credit card payments.
- To comply with the law.
- To contact you from time to time during treatment and post-treatment about new services, changes to services, special offers, surveys, clinic updates and other opportunities, by phone, email or addressed mail and voicemail.

I **consent** to the use of my personal information as described in this form. I **authorize** INITIO to obtain or release any medical information required to further my treatment(s). I **understand** that my scan image(s) may be used for research, educational, marketing and quality assurance purposes with all identifying information removed from the scan image(s) and with patient confidentiality maintained.

Signature: _____ Date: _____

Informed Consent for Electronic Communications

We value our relationship with you and would like to send you information electronically relating to INITIO. In order to do this, we are collecting your consent to receive electronic messages from us in the form of **appointment reminders**, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT." Opting in will provide INITIO with consent to communicate with you electronically. Opting out will indicate that you do not wish to receive **any** electronic communication from us.

☐ I would like to OPT IN.
☐ I would like to OPT OUT.

Email address: _____

Signature: _____ Date: _____

Financial Responsibility

You understand that the services offered at INITIO are NOT covered by MSP, and that fees are payable as follows:

- You will be responsible for $100 down payment of the current applicable fee at the time of booking your appointment.
- $50 of this deposit is FULLY NON REFUNDABLE. This is to cover out of pocket costs incurred by INITIO prior to your appointment.
- The remaining amount of the current applicable fee is payable at the time of service.

Cancellation Policy: We require 24 hours notice for any cancellations and reserve the right to charge a cancellation fee if not adhered to. In any event, $50 is non-refundable. If less than 24 hours notice is provided, your full $100 down payment is NOT refundable.

Signature: _____ Date: _____

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Consent for CT SCAN

Information Regarding CT Scans:

Your doctor has asked that a Computerized Tomography (CT) scan be performed. CT scanning is a non-invasive way to study all parts of your body. The technique itself is painless and can provide extremely accurate images. In many instances, a CT scan can decidedly decrease the need to perform surgery and CT scans have vastly improved the ability of doctors to diagnose many diseases earlier in their course and with much less risk than some methods. CT scans usually have no immediate side effects. The Radiologist and with the clinic and x-ray staff are fully trained in CT Diagnostics as well as patient safety and comfort.

BY SIGNING THE FORM BELOW, YOU ARE GIVING YOUR INFORMED CONSENT TO THE CT SCAN WITH CONTRAST PROCEDURE AND THAT THE ASSOCIATED RISKS OF THE ASSOCIATED RADIATION EXPOSURE HAVE BEEN EXPLAINED. YOU ALSO CONFIRM THAT YOU HAVE HAD THE OPPORTUNITY TO VOICE ANY QUESTIONS AND /OR CONCERNS WHICH HAVE BEEN ADDRESSED ACCORDINGLY.

Governing Law:

You agree that:

(i) all aspects of the relationship between you and INITIO Medical Group Inc., Premier Diversified Holdings Inc., and their respective affiliates, subsidiaries and agents, and their respective employees, directors, officers and any physicians or other independent health care providers related to or in association with INITIO Medical Group Inc., Premier Diversified Holdings Inc. including without limitation any medical or health care and treatment provided to you; and

(ii) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this form and waiver,

will be governed by and construed in accordance with the laws of the province of British Columbia and the laws of Canada applicable therein, without giving rise to any conflict of law provisions thereunder, and any actions in connection with or arising out of this Agreement will be commenced and maintained only in Vancouver, British Columbia.

I have read the above details and give my informed consent below. I give my consent to undergo scan. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition as described above. I understand that I may withdraw this consent at any time.

Signature: _____ Date: _____