



The Haliburton County Virtual Primary Care Clinic (HCVPPC)

Patient Consent

I, the undersigned, have reviewed and completed the Haliburton County Virtual Care Clinic Consent and Health History Questionnaire. The information I provided in the Health History Questionnaire is true and accurate to the best of my information and belief. If I did not know the answer to a question I indicated this.

I am aware that my visit will be conducted through the Ontario Telemedicine Network (OTN), a secure internet pathway, of the Government of Ontario, for the purpose of conducting health care examinations and consultations.

I am also aware that the Physician may determine that he or she is unable to conduct an examination or investigation because of the limits of the technology. I am also aware that there may be some medical and health issues which are not appropriate for this type of patient visit. I have been advised that in these circumstances I will be referred to another medical provider, clinic or hospital.

I consent to attending the session with the Physician and with a Registered Practical Nurse or Registered Nurse present (if you **do not** wish the RPN or RN to attend with you please indicate here by marking an X _____).

I also agree to the transfer of my health information including this Consent, the Health Questionnaire and the Physicians' Patient Record to the Haliburton Highlands Health Services or the Haliburton Family Medical Centre in the event I am referred to a scope within my circle of care and or follow-up.

I understand that although the Clinic is located within the Haliburton Highlands Health Services space, my care will be provided by a Physician of the Virtual Family Physician Network and my electronic patient record can be accessed by writing to the Virtual Family Physician Network by Mail: Suite 305, 1366 Yonge Street, Toronto ON M4T 3A7 or Fax: 1-855-700-5304.

Print Name

Day

Month

Year

Signature

Please Note: The Clinic Does Not Issue or Refill Narcotic Prescriptions. Thank you for your understanding.



The Haliburton County Virtual Primary Care Clinic (HCVPC) Cancellation Policy

The Physicians and Staff of the Haliburton County Virtual Care Clinic are pleased to be able to offer health care services to Residents of Haliburton County. Over the last year of operation, we are encountering difficulties concerning patients not showing up for appointments or cancelling at the last minute. When an appointment is cancelled late or a patient does not come it means our Nurse and Physician are not working for the entire period of the missed appointment. For some sessions this can be up to a half hour or more, which means that someone else who could have used the appointment is not seen. The large number of No Show Appointments and Last Minute Cancellations we are experiencing may end up forcing us to cancel the program and provide this needed service in other communities.

As of January 2021, We will be charging patients **\$30.00 for No Shows and Cancellations** made within 24hrs of the booked appointment time. If there are repeat No Show/Cancellations, our Physicians reserve the right to end the relationship with the patient.

We recognize that there can be last minute urgent matters which cause a patient not to attend and we will waive the fee in some circumstances.

Our hope is that we never have to charge a fee and we look forward to partnering with you in your healthcare.

Many thanks,

Sam Berman

Director, The Virtual Family Physician Network

Please indicate your agreement and understanding by signing and dating below.

Print Name

Day Month Year

Signature

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The Haliburton County Virtual Primary Care Clinic (HCVPPC) Patient History

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: Primary # _____

Secondary # _____

Health Card # _____ Version Code _____ Expiry Date _____

Address: _____

Email: _____

List all medications including over the counter medicines and herbal or other medicines:

List of medical conditions you have (knowing these conditions is important for your treatment plan including medications):

List any known allergies or sensitivities:

Specialists: Are you or have you been under the care of a Specialist, please provide name(s) and reason:

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What is the reason for your visit? It is helpful to know the general reason for your visit:

Name of previous family doctor or nurse practitioner if any and location:

Name of preferred pharmacy (we will fax prescriptions directly to your pharmacy):

Past Surgeries – (name of procedure, date, location and surgeon if known):

Emergency Contact- Name, Number and Relationship:

If you want to add any information, please do so here:

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