Dr. Nicolaas van As, Family Physician

Temporary Office: 348 Lyndoch St. Corunna, ON N0N 1G0
Telephone 519 813 9196
Fax 855 941 4641

New Patient Application Form

If applying as a family, please complete a separate application for each family member.

_____ _____
Surname Given Name

_____ _____ _____
Preferred Name if Applicable Age Gender

_____ _____
Health Card Number with Version Code Date of Birth (MM/DD/YYYY)

_____
Street Address, Apartment Number if applicable

_____ _____
City Postal Code

_____ _____ _____
Home Phone Mobile Phone Work Phone

_____
Email Address

In order to process your application, ALL documents MUST be completed, initialed, and signed where applicable.

Incomplete applications will NOT be followed up on or processed.

Please Review the Following Important Information

We encourage you to provide a valid email address that you can be contacted by. Once your application is processed and approved, you will receive an email notifying you of acceptance into Dr. van As' practice. Shortly after, office staff will telephone you to book your initial consultation with Dr. van As.

Due to the volume of applications received, the office cannot check the status of applications.

Please note that due to the family doctor shortage in Sarnia-Lambton, each application will be assessed on a case-by-case basis.

This application does not guarantee entrance into Dr. van As' practice.

Medical Information

Do you have a **legally** appointed Substitute Decision Maker or Power of Attorney for Personal Care?

- ☐ No
- ☐ Yes – Please provide SDM/POA documents and their information below

POA Name: _____ Relationship: _____

Telephone: _____ Email: _____

- ☐ The office should contact me initially with appointment and/or medical information
- ☐ The office should contact my POA with appointment and/or medical information

Do you currently have a family physician within Ontario?

- ☐ No
- ☐ Yes – Name/City they Practice in: _____

If you do not have a family physician in Ontario, please indicate the reason that most closely describes your situation:

- ☐ Until now, I have not had nor felt the need to have a family physician
- ☐ My previous family physician has retired or moved
- ☐ My previous physician was a pediatrician or other specialized physician
- ☐ Other: _____

Applicant Initials: _____

Medical History

If necessary, please attach separate pages.

Please list all **current** medical conditions (ie. asthma, depression, heart attack, chronic pain, etc.).

Please list any resolved medical conditions and past surgeries, including all relevant dates.

Please list any pertinent family medical history.

Applicant Initials: _____

Medications

Please list all current medications, prescription and non-prescription, that you are taking including name, dose, and frequency.

Please list any drug allergies and the reaction they cause (ie. anaphylaxis, hives, etc).

Pharmacy Information

Name of Pharmacy: _____ City: _____

Do you have your medications dispensed in a blister pack/dosette weekly?

- ☐ Yes
- ☐ No

Important: Dr. van As will **NOT** refill any prescriptions for patients prior to the initial consultation. Dr. van As will **NOT** refill any opioid prescriptions via telephone or by pharmacy request. All opioid renewals require an in-office visit.

Applicant Initials: _____

Opioid Information

Dr. Nicolaas van As maintains a **STRICT** opioid prescription policy in order to minimize the potential for abuse.

For applicants currently on long term opioid therapy:

- Prior treatment or existing opioid prescription does not guarantee that Dr. van As will prescribe opioids for you. Dr. van As will not prescribe opioids at the first patient visit.
- A thorough assessment including a review of all past medical records, referrals and investigations must first be undertaken to determine if treatment with opioids is appropriate.
- Extended/prolonged opioid use (7+ days) will require all patients to sign a Patient Agreement for Long-Term Opioid Therapy contract. This document will be provided at the first visit and Dr. van As will review them directly with you.
- Patients suspected of opioid prescription abuse will be subject to termination of the patient-physician relationship.
- At the time of the initial appointment, if either party decides that the patient-physician relationship would be ineffective for any reason, either party may terminate the relationship at that point without further commitment.

Should a long-term opioid prescription be applicable to you in the future, this information will be provided at that time.

Applicant Initials: _____

Consent to Use Electronic Communication

The Physician and office staff have offered to communicate using the following means of electronic communication ("the Services") [**check all that you consent to**]:

- ☐ Email
- ☐ Video Conferencing (ie. Doxy.me ®)
- ☐ Text Messaging (appointment reminders)
- ☐ Website/Portal
- ☐ None: I do not wish to communicate electronically

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form.

I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the

Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the

Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.

Applicant Initials: _____

- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications maybe disclosed in accordance with a duty to report or a court order.
- Video conferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, **the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.**
- If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and the Physician will **NOT** use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

  - ☐ Sexually transmitted disease
  - ☐ AIDS/HIV
  - ☐ Mental health
  - ☐ Developmental disability
  - ☐ Substance abuse
  - ☐ Other (specify):

Applicant Initials: _____

- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Instructions for communication using the Services

To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the Physician.
- **If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services.** Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above.

I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix.

Applicant Initials: _____

_____ _____

Patient Signature Date (MM/DD/YYYY)

Please return completed forms to Dr. van As' office by fax, mail, or to the office.