IMPERIAL MEDICAL CLINIC
4648 IMPERIAL ST, BURNABY, BC V5J 1B8
T: 604-409-8000 F: 604-409-4000
www.imperialmedicalclinic.ca

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

LAST NAME (AS APPEARS ON BC SERVICES CARD):	FIRST NAME (AS APPEARS ON BC SERVICES CARD):	
PREFERRED NAME (OPTIONAL):	PERSONAL HEALTH NUMBER:	DATE OF BIRTH (YYYY-MM-DD):
GENDER:	LANGUAGE (OPTIONAL): ☐ INTERPRETER REQUIRED	
ADDRESS: UNIT STREET CITY POSTAL CODE		
PRIMARY PHONE NUMBER: ☐ VOICEMAIL OK ☐ HOME ☐ CELL ☐ WORK	PRIMARY PHONE NUMBER: ☐ VOICEMAIL OK ☐ HOME ☐ CELL ☐ WORK	
EMAIL:		
EMERGENCY CONTACT: NAME	RELATIONSHIP	PHONE NUMBER

PARENT / LEGAL GUARDIAN / POWER OF ATTORNEY (P.O.A.) - COMPLETE IF APPLICABLE

1) NAME:	RELATIONSHIP: ☐ P.O.A.	PHONE NUMBER:
EMAIL:		
1) NAME:	RELATIONSHIP: ☐ P.O.A.	PHONE NUMBER:
EMAIL:		

REFERRAL INFORMATION

WHICH PHYSICIAN WERE YOU REFERRED TO?:	REFERRED BY:

MEDICAL HISTORY

DRUG ALLERGIES + OTHER ALLERGIES:

CURRENT MEDICAL ISSUES BEING TREATED:

PAST MEDICAL ISSUES:

PAST SURGERIES/PROCEDURES:

CURRENT MEDICATIONS (INCLUDE DOSAGE):

SPECIALISTS:

ALCOHOL: # DRINKS PER WEEK	SMOKING: # PACKS PER DAY	DRUGS: # USAGE PER/WEEK

FAMILY HISTORY

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PATIENT CONSENT FORM

Privacy and Sharing of Information

What personal information does this office collect?

We collect the following personal information:

- Identification and contact information (name, address, date of birth, emergency contact, etc.)
- Billing information (including but not limited to provincial plan, private insurer, credit card)
- Health information (symptoms, diagnosis, medical history, test results, reports and treatment, record of allergies, prescriptions, etc.)

Limits on collection

We only collect the information that is required to provide care, administer the care that is provided, and communicated with me. This office does not collect any other information or allow information to be used for other purposes without my express (i.e., verbal or written) consent — except where authorized to do so by law.

When and to whom does this office disclose personal information?

- Implied consent for provision of care: By virtue of seeking care from our office, my consent is implied (i.e., assumed) for my information to be used by this office to provide me with care and to share with other providers involved in my care.
- Disclosure to other health care providers: Relevant health information is shared with other providers involved in my care, including (but not limited to) other physicians and specialists, pharmacists, lab technicians, nutritionists, physiotherapists, and occupational therapists.
- Disclosures authorized by law: There are limited situations where our office is legally required to disclose my personal information without my consent. These situations include (but are not limited to) billing provincial health plans, reporting infectious diseases and fitness to drive, or by court order.
- Disclosures to all other parties: My express consent is required before this office will disclose my information to third parties for any purpose other than to provide me with care or unless our office is authorized to do so by law. Examples of disclosures to other parties requiring my express consent include (but are not limited to) third-party medical examinations, enrolment in clinical (research) trials, and provision of charts or chart summaries to insurance companies.

Can I withdraw consent?

I can withdraw my consent to have my information shared to other health care providers or other parties at any time, except where the disclosure is authorized by law. (Please discuss this with your physician first.)

☐ YES ☐ NO

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with other health professionals in my care as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission, unless required by law.

Appointment Cancellation and No Show Policy

A 24-hour cancellation policy is in effect for all appointments. I understand that cancellations or rescheduling with less than 24 hours' notice may be considered a late cancellation. To avoid a charge, I will cancel my appointment with at least 24 hours' notice.

I understand that missed appointments and late arrivals to a scheduled appointment may be considered a no show at the physician's discretion. This includes telephone and video appointments.

I understand that the fee for late cancellations and no shows is **$75.00** and will be implemented prior

to booking my next appointment.

I understand that if I do not show up for more than 2 appointments without notifying the clinic, I may be removed from the clinic roster and be filled by another patient.

☐ YES ☐ NO I have read and understand the Appointment Cancellation and No Show Policy and agree to its terms.

Access to PharmaNet

☐ YES ☐ NO I authorize all physicians and staff at Imperial Medical Clinic directly involved in my care to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me or for the purpose of monitoring drug use by me. I understand withdrawal of this consent (access to PharmaNet) must be in writing and delivered to the above-named/consented physicians.

Medical Coverage

☐ YES ☐ NO I understand that some services provided are not a covered benefit of the Medical Services Plan of BC (MSP). These services may be provided at an additional cost to me.

Zero Tolerance to Abuse or Aggression

Imperial Medical Clinic is committed to providing a **safe**, **secure,** and **respectful environment** for all patients and staff.

Words or actions that make others feel threatened or demeaned will not be tolerated, and decisive action will be taken to protect patients and staff.

Disruptive Behaviour:
Imperial Medical Clinic considers the use of inappropriate words, actions, or inactions as disruptive behaviour.

Inappropriate Actions/Inactions:
- Violence (physical attacks or threats of harm)
- Intimidation
- Throwing, damaging property, or breaking things
- Unwelcomed physical contact
- Failure to observe IMC policies and/or contracts
- Refusing to leave the property

Inappropriate Words (in person, by phone, or any means of communication):
- Abusive language and yelling
- Disrespectful or demeaning language/comments
- Remarks, jokes, or innuendos that degrade, ridicule, or offend
- Discriminatory remarks
- Threats or threatening behaviour
- Bullying
- Sexual Harassment

Immediate action will be taken when incidents described above occur.

Individual(s) may be asked to leave, the police may be called or the individual(s) may face dismissal from our practice.

☐ YES ☐ NO I understand and agree to adhere to the Zero Tolerance to Abuse Policy.

Research and Tools of Medical Innovation

☐ YES ☐ NO I would like to be presented the opportunity to participate in research and/or tools of medical innovation. I understand I have the right to withdraw my consent at any time, in writing.

Consent for Telehealth Consultation and Treatment

To better serve the needs of people throughout our region, some health care services are now available by two-way interactive video communications and/or by the electronic transmission of information, which may assist in the evaluation and treatment of health care problems. Referred to as "telemedicine" or "telehealth" this means that I may be evaluated and treated by Imperial Medical Clinic and its practitioners ("practitioner") by telemedicine. Since this may be different than the type of consultation or visit with which I am familiar, I understand and agree to the following:

1. My practitioner may be at a different location from me. A physician or other provider ("local provider") may be at my location with me to assist in the telehealth session at my consent. Consultation may also take place at my home without a local provider present.

2. The telemedicine process may consist of transmission of video or digital photographs of me or of transmission of x-rays, test results, or details of my medical record. These will be transmitted to and discussed with my practitioner.

3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part my practitioner and Imperial Medical Clinic, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. A documented record of the telehealth session will be kept in my medical record by my practitioner at Imperial Medical Clinic.

5. I understand that telemedicine based services and care may not be as complete as face-to-face services. My practitioner, at their discretion, may terminate a telehealth session and request a face-to-face visit if a telehealth session is deemed insufficient.

6. As a patient, I have the right to:
   A. Refuse the telehealth session, or stop participation at any time.
   B. Limit the physical examination during the telehealth session.
   C. A confidential and private environment during a telehealth session.

☐ YES ☐ NO I understand and agree.

Consent for Electronic Communication

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communications. I understand and accept the risks outlined in this consent form associated with the use of services in communications with the physician and physician's staff.

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.

☐ YES ☐ NO I understand and agree.

Notice of Jurisdiction

The College of Physicians and Surgeons of British Columbia (CPSBC) is the regulatory body for all licensed physicians in BC. Following the CPSBC's Practice Standard on Virtual Care, physicians must be aware of and comply with the licensing requirements in British Columbia and in the jurisdiction where the patient is located. Some jurisdictions require physicians and surgeons to hold an additional licence to treat a patient located in that jurisdiction. This practice standard places additional constraints on physicians, particularly when a patient is not located in BC.

☐ YES ☐ NO I understand that, if I am located outside of BC, physicians at Imperial Medical Clinic will not be able to provide telehealth or telemedicine services. I will ensure that I am physically located in the jurisdiction of BC during my appointment.

Patient Inactivity

☐ YES ☐ NO I understand that I may be deactivated/de-rostered from my family doctor if I remain inactive for a period of more than 3 years. While Imperial Medical Clinic will make a reasonable attempt to contact me (with the contact information provided) prior to this, I am responsible for ensuring my contact information is promptly up to date.

Acknowledgement and Signature

By signing below, I confirm that I have reviewed the form and understand Imperial Medical Clinic's policies. I am aware that choosing "**No**" to certain items may impact services or communication options. I recognize my role in managing my care, appointments, and communication. I understand that I may request clarification on any item at any time.

Patient Signature

Printed Name	Signature	Date Signed (YYYY-MM-DD)

Representative Signature *(complete if applicable)*:

If you are signing on behalf of the patient, please check the appropriate box below.

I am signing on behalf of the patient as their:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney (P.O.A.) ☐ Other: _____

By signing, I confirm that I am legally authorized to act on behalf of the patient and have reviewed the form with them as appropriate.

Printed Name	Signature	Date Signed (YYYY-MM-DD)

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RELEASE OF MEDICAL RECORDS FORM

PROVIDER OR FACILITY RELEASING RECORDS

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ Phone: _____

PHN: _____ Address: _____

DOB: _____ Email: _____

REQUESTED RECORDS (please specify date range if applicable)

☐ Labs: _____ ☐ Consultations: _____

☐ Imaging: _____ ☐ All Records: _____

☐ Other (please specify): _____

PURPOSE OF REQUEST

☐ Transferring care to a new family doctor or nurse practitioner

☐ For ongoing care with specialists, physiotherapists, naturopaths, or other healthcare providers

☐ Moving out of province

☐ Personal Use

☐ Other (please specify): _____

*For **insurance** and **legal purposes**, please have the third party fax their request along with your signed authorization to release medical information to our office at **604-409-4000**.*

RECIPIENT OF RECORDS

Please select one: ☐ Imperial Medical Clinic ☐ Myself (Patient) ☐ Other (complete below)

Recipient Name: _____

Address: _____

Phone: _____ Fax: _____

AUTHORIZATION

I understand that this service is not covered by MSP and I am responsible for any fees that may occur.

☐ I, the patient, hereby authorize the Provider/Facility to release the records requested to the named Recipient of Records.

☐ By signing below, I confirm that I have legal authority to act on behalf of the patient and I hereby authorize the Provider/Facility to release the requested records to the named Recipient of Records.

Relationship to Patient: _____

_____	_____	_____
Printed Name	Signature	Date Signed (YYYY-MM-DD)