Lakeside Natural Health
CENTRE

Lydia Henry, B.Sc. CAT(C). DOMP
Osteopathic Manual Practitioner, Athletic Therapist
Lakeside Natural Health Centre, 7 Elmwood Avenue North
Port Credit, Ontario, L5G 3J8 **Phone:** 905.274.4375 **Fax:** 905.274.6209

Patient Information

TODAYS DATE: ________________________________

NAME:____

ADDRESS:____

CITY:__________________________________ PROVINCE:______________ POSTAL CODE:___________

HOME PHONE:________________________________ OTHER PHONE:______________________________

BIRTH DATE:____ AGE:____________________________

REFERRED BY:____

EMERGENCY CONTACT PERSON:____

PHONE NUMBER:____

DOCTOR NAME:____

ADDRESS:____

PHONE NUMBER:____

EMAIL: ____

(All information is confidential)

I,________________________________, hereby consent to treatment by Lydia Henry and discussion of my file with my family doctor or specialist involved in my medical case, with my permission

PLEASE NOTE:

Please sign that you have read and understood this policy and that all the information provided is correct

____________________________	____________________________	____________________________
Patient Name	Signature, or Signature of Legal Guardian	Date signed

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CANCELLATION POLICY & PAYMENT OPTIONS

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. The clinic will retain a record of your credit card only to process missed appointment fees and a receipt will be promptly issued for any missed appointment fees. We appreciate your cooperation with this clinic policy.

Credit Card Information

Card # ____ Exp. _________________ 3 Digit Code ______________

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:
Cash, Cheque, Debit, Visa and MasterCard

Patient Confirmation

By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I __________________________ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

Signature _______________________________________ Date ______________________