

STEPS TO WELLNESS

NATURAL HEALING & HEALTHY LIVING

GUIDANCE AND SESSIONS—NATURAL MODALITIES FOR WELLNESS, LIFESTYLE, AND HEALTH-



Natural Health Practitioner Alexandra Gellman offers personal consultation and guidance as well as Simple Steps to Wellness workshops, keynote talks, presentations, and tele-coaching to boost health naturally. Alexandra specializes in teaching trusted, simple approaches to health, nutrition, and showing how to improve your life (and longevity)— in easy, do-able steps.



CONSENT TO USE ELECTRONIC COMMUNICATIONS

PATIENTS: Please complete each section of personal information on this page, initial the bottom of each page and any other required field noted through this document.

HOMEOPATH INFORMATION:

Name: Alexandra Gellman PhD, HOM, RBC

Address: 960 Lawrence Ave. West, Toronto

Email : alex@alexgellman.com

Phone (as required for Service): 416 456 4357

Website: alexgellman.com

The Homeopath has offered to communicate using the following means of electronic communication (“the Services”):

- ✓ Email
- ✓ Text messaging including instant messaging
- ✓ Social media
- ✓ Video conferencing (including Skype/Face Time)
- ✓ Website/portal

Other _____

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 Homeopath and the Homeopath’s staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Homeopath 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 Homeopath or the Homeopath’s staff using the Services may not be encrypted. Despite this, I agree to communicate with the Homeopath or the Homeopath’s staff using these Services with a full understanding of the risk.

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

Patient name: _____

Patient address: _____

Patient home phone: _____ Patient mobile phone: _____

Patient email: _____

Other account information required to communicate via the Services (if applicable):

Patient signature:

Date:

This document has been adapted for the use of registrants of the College of Homeopaths of Ontario with permission from the Canadian Medical Protective Association.

APPENDIX

Risks of using electronic communication

The Homeopath 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 Homeopath 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.
- 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 Homeopath 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 may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype, FaceTime or Zoom 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 Homeopath will attempt to review and respond in a timely fashion to your electronic communication, the Homeopath cannot guarantee that all electronic communications will be received, 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 Homeopath 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 Homeopath's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning homeopathic assessment 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 authorized staff, may have access to those communications.
- The Homeopath will not forward electronic communications to third parties, including family members, without your prior written authorization and consent, except as authorized or required by law.
- You agree to inform the Homeopath of any types of information you do not want sent via the Services 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 Homeopath is not responsible for information loss due to technical failures associated with your software or internet service provider.

Patient initials _____

Please fax to 416 787 8818 or email to alex@alexgellman.com

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COACHING, WORKSHOPS, CONSULTATIONS. CONTACT alex@alexgellman.com 416 456-4357

APPENDIX CONTINUED

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 Homeopath of any changes in the patient's email address, contact 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. "follow-up appointment"), and your full name in the body of the message.
 - Review all electronic communications to ensure they maybe clearly understood by the recipient, and that all relevant information is provided before sending to the Homeopath.
- Ensure the Homeopath is aware when you receive an electronic communication from the Homeopath, 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 Homeopath.
 - 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 Homeopath'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:

(patient to initial)

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

Patient Signature

Date

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STEPS TO WELLNESS — NATURAL HEALING & HEALTHY LIVING

HOMEOPATHIC CONSENT AND RELEASE FORM

Homeopathy is a system of medicine that offers a holistic and individualized approach to your health. It utilizes dilute substances derived mainly from plant, animal, and mineral sources. The objective of the homeopathic examination is to consider your entire “picture”. It represents your current state of health (physical, mental and emotional) and enables a Homeopath to select a *homeopathic* medicine that is best suited to you at this time. Nutritional assessment and counseling is often a part of the intake process. When used correctly under the supervision of a qualified practitioner, Homeopathy is considered to be a safe integrative/preventative system of health care. It is not intended to be a substitute for allopathic or traditional medicine. ***The therapy and information offered should not be construed by you, the client, to be a medical diagnosis of any disease or injury. You should consult with your physician for any serious medical condition.***

PLEASE READ CAREFULLY AND SIGN AT THE BOTTOM. WE ARE HAPPY TO ADDRESS ANY QUESTIONS OR CONCERNS.

I acknowledge that I have the option of seeking/continuing conventional medical care from a medical doctor and that homeopathic treatment and conventional medical treatments are different but can complement each other. I confirm that there has been no suggestion made to me that I refrain from seeking or following conventional medical treatment. I recognize that input from my medical doctor is welcome, and the information will be used to augment the homeopathic case-taking process. I am free to withdraw my consent and to discontinue treatment at any time.

While Alex Gellman has had extensive training in the science and art of Homeopathy, I acknowledge that she is not a medical doctor. I confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

I fully understand what has been presented to me with regards to the nature of homeopathic medicines and their safety, and the credentials of my homeopath.

I understand that a block of time has been set aside for my private appointment, and that a 24-hour notification is required if I must cancel. I understand that there is a full charge for appointments canceled less than 24 hours in advance.

I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment.

I understand that phone consultations will be billed at the usual hourly rate.

I understand that any Remedies prescribed will be extra—instructions will be provided for purchase.

I understand that current fees for consultations are as follows, but that there may be changes in the fee structure in the future.

Initial Consultation	\$180.80 (60 minutes) or \$ 272.00 (90 minutes)	
In Depth Initial Consult	\$360.00 (120 minutes)	
Follow-up Consultation	\$160 (45 minutes)	
Follow-up Consult	\$180 (60 minutes) or \$120.00 (30 minutes)	ALL PLUS GST/HST

To end of June 2020 virtual and telephone consultation— \$36 per half hour & \$72 for one hour

I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Name: _____ Signature: _____ Date: _____

If patient is under 18 years, parental signature is required

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STATEMENT OF ACKNOWLEDGEMENT

Each person seeking care with Alexandra Gellman/ the Guru Clinic should understand that the practitioner is Homeopathic, and not medical. If standard medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

At your personal interview/appointment, we will use Vega testing (an electro- acupuncture feedback technique), and Quantum Magnetic Resonance Analysis. This is for research only and not for diagnosis or treatment of disease.

Each client must sign the following document before any treatment will be rendered. Your signature acknowledges the following:

1. That you have read all the foregoing information and that you understand that the ultimate responsibility for your health is your own.
2. That you understand that the practitioner in this office works within the Homeopathy scope of practice and is not a medical doctor.
3. That you understand that the practice of Vega electro-acupuncture and Quantum Magnetic Resonance Analysis, at this time, are considered non-standard. (The Vega and QMRA are available only with in-person appointments/not remote consultations.)
4. That you understand that treatment here and/or referral to other health practitioners is based upon the assessment of conditions revealed through personal history and interview.
5. That while changes in dietary habits are not an absolute prerequisite for treatment, you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the desired results.
6. That you are not an agent for any private, local, county, provincial, or federal agency attempting to gather information without so stating your intentions at the beginning of the relationship.
7. That you are accepting or rejecting this care out of your own free will and choice.
8. We at the Guru and Associates Inc. Clinic are not responsible for the coverage of this treatment under your personal insurance program.
9. That you accept full responsibility for any fees incurred during care and treatment, and that you agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.

I, (NAME:) _____

(SIGNATURE:) _____

HAVE READ, UNDERSTOOD, AND ACKNOWLEDGE THE ABOVE STATEMENTS.

Date: _____

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DECLARATION AND RELEASE

I, _____, of the following address:
(name)

acknowledge and declare that I have been given the option of seeking / continuing conventional medical care from a qualified medical doctor, and I have been properly informed that Homeopathic treatment and medical treatment are not mutually exclusive.

I confirm that there has been no suggestions made to me by A. Gellman (Villada) HD, RBC to refrain from seeking or following conventional medical attention.

I understand:

1. that medical therapy and Homeopathic / drugless therapy are different kinds of therapies and modalities of treatment,
2. the differences in the therapies and modalities of treatment, and
3. the differences in the therapies and treatments rendered by each of a medical practitioner and Homeopathic / drugless therapy practitioner.

Dated and Signed this _____ day of _____, _____

Signed, Sealed, Delivered in the presence of:

_____ CLIENT _____ WITNESS

_____ Print name _____ Name

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STEPS TO WELLNESS

NATURAL HEALING & HEALTHY LIVING

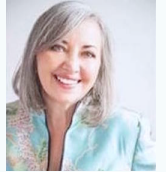
GUIDANCE AND SESSIONS—NATURAL
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AND HEALTH-



ALEX GELLMAN
& GURU
ASSOCIATES

SIMPLE STEPS TO WELLNESS

Natural Health Practitioner Alexandra Gellman offers personal consultation and guidance as well as Simple Steps to Wellness workshops, keynote talks, presentations, and tele-coaching to boost health naturally. Alexandra specializes in teaching trusted, simple approaches to health, nutrition, and showing how to improve your life (and longevity)— in easy, do-able steps.



EMAIL CONSENT

I am requesting your consent to send you emails in the future.

Below are the different types of email correspondence we may send. Please check what we may forward to you.

Please put a checkmark beside each category of information you would like.

- Email pertaining to your consultation/copies of reports
- Email to celebrate your birthday
- Email to remind you of upcoming appointments
- Email to advise you of upcoming health presentations
- Email with a health/wellness newsletter from time to time

You can withdraw your consent to the above at any time by contacting me.

Signature: _____

Date: _____

Print Name: _____

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STEPS TO WELLNESS

NATURAL HEALING & HEALTHY LIVING

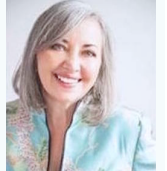
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48-HOUR CANCELLATION POLICY

Please note that we charge a cancellation fee if you miss your appointment with less than 48-hours notice. This usually includes Tele-Wellness sessions as well as in-person consultations. This policy is in place out of respect for clients— cancellations with less than 48-hours notice are difficult to fill. If you cancel without sufficient notice, last-minute, or don't show, you prevent someone else from filling that spot.

By signing below, you acknowledge that you have read and understand the cancellation protocol for Alexandra Gellman and agree to the charge being placed on your credit card or paid at your next visit as described above.

Thank you for your understanding and cooperation.

Signature: _____

Date: _____

Print Name: _____

Please fax to 416 787 8818 or email to alex@alexgellman.com

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STEPS TO WELLNESS

NATURAL HEALING & HEALTHY LIVING

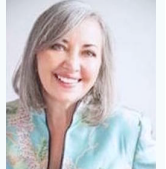
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COVID-19

It's essential that we have a complete picture of your health and well-being. Please complete this questionnaire and forward to us 24 hours before your scheduled consultation. If you check yes and have not seen a medical practitioner, or if symptoms are of recent onset, let us know ASAP. Thank you.

1. Do you have a fever, new onset cough, worsening chronic cough, shortness of breath, or difficulty breathing?
2. Did you have close contact with anyone with acute respiratory illness or who travelled outside of Canada in the past 14 days?
3. Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
4. Do you have two or more of the following symptoms:
5. If 65 or older, do you have any of the following symptoms:

- Sore throat
- Headaches
- Pink eye (conjunctivitis)
- Hoarse voice
- Unexplained fatigue/malaise
- Runny nose/sneezing without other known cause
- Difficulty swallowing
- Diarrhea
- Nasal congestion without other known cause
- Decrease or loss of sense of taste or smell
- Abdominal pain
- Chills
- Nausea/vomiting

- Delirium
- Acute functional decline
- Unexplained or increased number of falls
- Worsening of chronic conditions
- A heart condition
- High blood pressure
- High cholesterol
- Diabetes
- Do you take medications for these or other chronic conditions?

SIGNATURE:

PRINT YOUR NAME:

DATE

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PRIVACY POLICY

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

We care for your consent. Privacy of your personal information is an important part of Guru & Associates Wellness Inc. office providing you with quality holistic wellness care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Alexandra Gellman acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

We have outlined what our office is doing to ensure that:

- Only necessary information is collected about you
- Unless directed by you no information will ever be disclosed to anybody else
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
- Our privacy protocols comply with privacy legislation, standards of our regulatory bodies, the Homeopathic Medical Council of Canada, the Iridology Association of Canada, the International Organization of Nutritional Consultants, and the law body.

Do not hesitate to discuss our policies with myself, or any member of our office staff. (416) 456-HELP (4357)

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

PATIENT CARE

- To provide safe and efficient patient care and services in relationship to homeopathic care generally
- To assess your wellness needs, provide wellness care, and advise you of treatment options
- To communicate with other treating health-care providers, including specialists and other referring practitioners.
- To ensure continuous high quality service.

PATIENT COMMUNICATION

- to enable us to contact and maintain communication with you
- to book and confirm appointments
- to invoice for goods and services
- to process credit card payments
- to distribute information on Guru & Associates Wellness Inc. services by phone, internet and / or mail
- to allow us to use information for educational and demonstration purposes on an anonymous basis e.g. eye photographs.

LEGAL REQUIREMENTS

- to comply with agreements / undertakings entered into voluntarily by the patient with the Homeopathic Medical Council of Canada, the Iridology Association of Canada, or the International Organization of Nutritional Consultants, including the delivery and / or review of the patients’ charts and records in a timely fashion for regulatory and monitoring purposes
- to deliver your charts and records to the homeopath’s and / or nutritional consultant’s insurance carriers
- to collect unpaid accounts.
- to assist this office to comply with all regulatory requirements, and comply generally with the law
- your right to access, update and correct your information

At *Guru & Associates Wellness Inc.*, we trust and value the accuracy of your personal information. At all times, you have the right to ask for access to the information in your file and request that we update your file for accuracy or correct any errors.

Patient Signature

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and / or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and / or disclosure of your personal information, we will seek your approval in advance.

Our office will not under any conditions supply your insurer with your confidential wellness history without your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see my file at any time.

I agree that Alexandra Gellman or Guru & Associates Wellness Inc. can collect, use and disclose personal information about myself as set out above in the information about the office’s privacy policies.

signature

print name

date

signature of witness