Dear New Patient,

Welcome to my practice! As your family physician, I aim to provide timely and compassionate medical care. This letter is here to answer your initial questions and ease your orientation to the clinic.

My Approach to Medical Care

As your family physician, I will look after your general medical care with an emphasis on preventative care and healthy choices. My recommendations on testing, screening and referrals will be made based on your personal risk factors, preferences, medical history and family history. I avoid unnecessary medications and testing as these can cause adverse outcomes.

Availability

My clinic hours are as follows:

- Monday 6:30pm-8pm, for urgent appointments only and available on a week-by-week basis
- Wednesday 9am-1pm, 2pm-5pm
- Thursday 1pm-4pm, 5pm-8pm
- Friday 9am-12pm

Some appointments are saved for same-day appointments. These fill quickly, please call early to book.

Appointments

- Standard appointments are **15 minutes**
  - This provides enough time to properly address **one or two** issues per visit.
  - If you have more than two items, please book additional appointments
- Please arrive on time for appointments
  - Arriving late will decrease your appointment time and you may need to book another appointment to address remaining issues
- If you are over 10 minutes late for a 15 minute appointment, your appointment will be considered a no-show unless I can see you, if time permits.
- Provide **24-hours' notice** to avoid being considered a no-show.
  - You will be billed $50 on your second and subsequent no-shows.
  - Frequent lateness and no-shows may result in being discharged from my practice.
- Some issues require more time, so I **strongly recommend** telling us the reason for your visit.

Administrative Processes

- Please allow one week before test results are ready to be discussed
- Referrals are typically sent out within 3 business days. If you do not hear back about the date and time of your specialist appointment after 3 weeks, please give our office a call.
- If you need a form filled, please tell the staff to ensure adequate time is allocated. Sometimes, forms cannot be completed on the same day and may take up to 1-2 weeks to complete.

Urgent After-hours Clinic

There is an after-hours clinic for evenings and weekends. This is run on a rotation-basis by the physicians in our office. By coming to this clinic instead of a walk-in clinic, the physician can see your medical information and ensures that your records are updated properly.

- This clinic is only for urgent issues that cannot wait until the next clinic day
  - **It does not address routine check-ups, follow-ups, prescription renewals or referrals.**
- Going to a walk-in clinic when rostered with a family physician, like myself, results in financial penalties to Cachet Medical Centre by the Government.
- If you are having an emergency, please proceed directly to the nearest Emergency Room.

Prescriptions

- Renewals will only be made for medications for periods of 90 days. If it has been longer than 90 days or you require a new medication, please book in to have your medication needs assessed.
- **I do not prescribe narcotic medications (e.g. Percocet, Oxycocet, Morphine, Dilaudid, Tylenol#3s) unless when tapering off** in accordance with current recommendations for safe prescribing and use by my regulatory College. These medications cause addiction and numerous dangerous side effects leading to falls and inability to drive. I can work with you to find other interventions to address your concerns.
  - While tapering off, you will need to sign a narcotic contract and may need to participate in urine drug tests.

Non-OHIP Services

Common things that are not covered by OHIP includes cosmetic procedures, travel medicine, some forms, sick notes, TB skin testing, drivers' physicals, some vaccinations and certain administrative requests. When requesting these, the cost will be provided upfront.

Clinic Etiquette

We strive to be honest and respectful in all of our interactions and ask the same of you. Disrespectful behaviour, such as yelling, insulting, swearing, threats or aggression will not be tolerated and will result in being discharged from my practice.

We are always happy to answer any further questions. Thank you for your understanding and I look forward to being your family physician!

Sincerely,

Dr. Jacqueline Sing Woon Ho

亲爱的新病人：

欢迎来到我的診所!作为你的家庭医生, 我的目标是提供及时、富有同情心的医疗服务。这封信是会回答你最基本的问题, 方便你了解诊所。

我对医疗的態度

作为你的家庭医生, 我会照顾你的一般医疗服务, 重点是预防性的护理和有益健康的选择。我对检测、筛查和转诊的建议将根据你的个人风险因素、嗜好、病曆和家族史提出。我会避免不必要的药物和测试, 因为这些或許会导致不良的结果。

提供服務

我的门诊时间如下:

- 星期一下午 6 时 30 分至晚上 8 时, 只供紧急预约, 每周提供
- 星期三上午 9 时至下午 1 时, 下午 2 时至 5 时
- 星期四下午 1 时至 4 时, 下午 5 时至 8 时
- 星期五上午 9 时至下午 12 时

由于部份时間是预留给当天预约期用。餘額不多, 请提前打电话预订。

診症

- 标准診症时间为 **15** 分钟
  - 为每次访问提供足够的时间来正确診斷及解决一个或两个病患问题.
  - 如果您有两个以上的病患项目, 请再预订額外的预约期
- 请准时到达
  - 迟到会减少你的診症时间, 你或可能需要再预约一次, 以解决剩余的问题
- 如果你在 15 分钟的预约中迟到超过 10 分钟, 除非时间允许我可以见你診症, 否则你的预约将被视为没有露面。
- 提前 **24** 小时通知, 避免被视为未露面。如無通知
  - 您将在第二次及以后的未出現中每次会被收取 50 加元的费用.
  - 经常迟到或不应约可能会导致阁下在我的病人名錄內被剔除.
- 有些病情或需要更多的时间, 所以我强烈建议預先告诉我们你来访的原因。

行政流程

- 一般測試结果会在一周后預約讨论
- 专科推荐通常在 3 个工作日内发出。如果您在 3 周后没有收到专家预约的日期和时间, 请至电话到我们的診所。

- 如果您需要填写表格, 请告诉工作人员, 以确保分配足够的时间。表单有时无法在同一天内完成, 可能需要长达 1-2 周才能完成。

紧急非辨工时間诊症

診所提供晚上和周末提供非辨工时間诊症。是由我们診所的医生轮流当值的。讓你能夠到自己的診所看病而不是去" 無需预约诊所" , 我們的医生可以看到你的医疗记錄, 提供適當診症， 并确保你的记录得到适当的更新。

- 這时段诊所只处理不能等到下一个诊所日的紧急问题。
  - 它不涉及例行检查、随访、处方延期或转诊.
- 你如果已登记在家庭医生的名册上, 但走去一家 " 無需预约诊所 " 看病, 会導至政府对 cachet 医疗中心的经济处罚。
- 如果您有紧急情况, 请直接前往最近的医院急症室。

处方

- 只能提供最長 90 天的药物更新。如果超过 90 天, 或者您需要新的药物, 请预约診症, 以评估您的药物需求。
- 我不会开麻醉药品 (如 Percocet, Oxycocet, Morphine, Dilaudid, Tylenol#3s)，除非 根据监管学院目前对安全处方和使用的建议正在逐渐地減少使用情况。这些药物会导致成癮和许多危险的副作用导致跌倒和无法驾驶。我会和你一起寻找其他措施来解决你的关切。
  - 在逐渐减少使用的同时, 你需要签署一份麻醉药品合同, 可能需要参与尿液药物测试.

非 OHIP 服务

OHIP 不包括的常见内容包括美容程序、旅行药物、某些表格、疾病笔记、结核病皮肤检查、司机体检、某些疫苗接种和某些行政要求。当提出这些服務要求时, 診所会预先提供费用清單。

诊所礼仪

我们努力在我们所有的互动中诚实和尊重, 并向你们提出同样的要求。任何不尊重他人的行为, 如大喊大叫、侮辱、骂人、威胁或侵略, 是不能容忍的, 会导致阁下在我的病人名錄內被剔除。

我们总是乐于回答任何进一步的问题。谢谢你的理解, 我期待着成为你的家庭医生!

真诚

何蘩媛醫生

PLEASE COMPLETE THE INFORMATION SHEET BELOW IN BLOCK LETTERS

PATIENT NAME: FIRST _____ LAST _____

DATE OF BIRTH: d_____ m_____ y_____ SEX: M / F/: _____

HEALTH CARD NO : ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ VERSION CODE: ___ ___

CONTACT PERSON (Optional): Name_____ Tel. # _____

REASON FOR SEEKING A NEW GP:

_____

PATIENT PROFILE:

MARITAL STATUS: _____

NO. OF CHILDREN: _____

OCCUPATION: _____

HEIGHT & WEIGHT: (to be checked by staff)

HEIGHT: _____ WEIGHT: _____

SOCIAL PROFILE:

SMOKING: YES ____ NO ____ IF YES: _____ PACKS PER DAY

ALCOHOL: YES ____ NO ____ IF YES: _____ PER WEEK

RECREATIONAL DRUGS: YES ____ NO ____ IF YES: TYPE(S): _____

FAMILY PROFILE:

MOTHER: DECEASED? YES____ NO ____ FATHER: DECEASED? YES ____ NO____

YEAR OF BIRTH: _____ YEAR OF BIRTH _____

LIST ANY KNOWN HEALTH ISSUES LIST ANY KNOWN HEALTH ISSUES

_____ _____

_____ _____

NUMBER OF SIBLINGS: SISTERS: _____ BROTHERS: _____

ANY KNOWN HEALTH ISSUES:

_____

_____

_____

PLEASE TURN OVER....

PERSONAL HEALTH:

CURRENT MEDICAL ISSUES (EG: DIABETES, HYPERTENSION, ETC):

_____

_____

PREVIOUS MEDICAL HISTORY INCLUDING SURGERIES: (EG: APPENDECTOMY/TONSILLECTOMY) PLEASE PROVIDE THE YEAR IF POSSIBLE:

_____

_____

ALLERGIES: (EG: DRUG, FOOD, ENVIRONMENTAL):

_____

_____

CURRENT MEDICATIONS: (PLEASE LIST THEM BELOW OR PROVIDE US WITH A LIST ON A SEPARATE SHEET)

_____ _____

_____ _____

_____ _____

IMMUNIZATION RECORD: (PLEASE PROVIDE US WITH A COPY OF YOUR IMMUNIZATION RECORD)

DATE OF LAST TETANUS VACCINE: _____

ADDITIONAL INFORMATION:

_____

_____

_____

PHYSICIAN/STAFF/PATIENT E-MAIL COMMUNICATION CONSENT FORM continued

INSTRUCTIONS FOR COMMUNICATION BY E-MAIL

To communicate by e-mail the patient shall:

- Limit or avoid using an employer's computer.
- Inform the physician or staff of any changes in patient's e-mail address.
- Include in the e-mail: the category of the communication in the e-mail's subject line and the name of the patient in the body of the e-mail.
- Review the email to make sure it is clear and all relevant information is provided to the physician or staff.
- Withdraw consent only by e-mail or written communication to the physician or staff.
- **The patient should not rely on e-mail when seeking immediate assistance. Rather the patient should call the physician's office for an appointment**.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand that the risks associated with the communication of e-mail between the physician, staff and me, and consent to the conditions outlined herein, as well as any other instructions that the physician or staff may impose to communicate with patients by e-mail. I acknowledge the physician's right to, upon the provision of written notice; withdraw the option of communicating through e-mail.

PATIENT NAME: _____

E-MAIL: _____

OHIP #: _____

PATIENT SIGNATURE _____

DATE _____

WITNESS SIGNATURE _____

DATE _____

CACHET FAMILY PHYSICIANS

PHYSICIAN/STAFF/PATIENT E-MAIL COMMUNICATION CONSENT FORM

RISKS OF USING E-MAIL

The patient should not agree to communicate with the physician or the physician's office via e-mail without understanding and accepting these risks. The risks include, but are not limited to the following:

- The privacy and security of e-mail cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep e-mails that pass through their system.
- E-mail is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail once it has been sent.
- E-mails can introduce viruses into a computer system and potentially damage or disrupt the computer.
- E-mail can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician, staff or patient. E-mail senders can easily misaddress an e-mail, resulting in it being sent to many unintended and unknown recipients.
- E-mail is indelible. Even after the sender and recipient have deleted their copies of the e-mail, back-up copies may exist on a computer or in cyberspace.
- Use of e-mail can increase the risk of such information being disclosed to third parties.
- E-mail can be used as evidence in court.

CONDITIONS OF USING E-MAIL

The physician or staff will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, the physician or staff cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician or staff. Thus patients must consent to correspond by e-mail. Consent to the use of e-mail includes agreement with the following conditions:

- E-mails to or from the patient will become a part of the patient's electronic medical record.
- The physician or staff will not forward e-mail to independent third parties without the patient's prior written consent.
- The physician or staff will endeavour to read and respond promptly to an e-mail from the patient, the physician or staff cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient should not use e-mail to request urgent appointments.
- If the patient has not received a response from an e-mail within a reasonable period of time, it is the patient's responsibility to follow up by phone 905-887-2222.
- The patient is advised not to use e-mail for communication regarding sensitive medical information, instead, the patient should call 905-887-2222 to book an appointment. The physician or staff is not responsible for information loss due to technical failures.

Continued....>

9255 Woodbine Avenue, Suite 2, MARKHAM, ONTARIO L6C 1Y9
(905) 887 2222 Fax (905) 887 3655

Ontario

Ministry of Health and Long-Term Care

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

☐ or same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

☐ or same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

PG13307

Dr. Jacqueline Ho
EAST GTA FHG
BILLING NO. 035355 GROUP NO. FXAR

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

PHYSICIAN COPY

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

Consent to Release Personal Health Information

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry *(see box below);*
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario);*
c) the Patient Enrolment Model to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor; or
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above);*
b) my family doctor leaves this Patient Enrolment Model;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Model to which my family doctor belongs regularly provides services.

Contact Information:

Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9

Call: INFOline 1 888 218–9929
TTY 1 800 387–5559

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)