SARA RUIZ, N.P.
#402-20395 Lougheed Hwy
Maple Ridge, BC V2X 2P9
Ph: 604 465 3900
Fax: 604 465 3990

Date:_____

New Patient Intake Form

Thank you for completing this form. Your honest answers help me provide the best care possible. This is a judgment-free space, and all information collected is used to guide your care.

1. Personal Information

Full Legal Name:_____ **Preferred Name:**_____
Date of Birth: _____ **Age:**_____ **Care Card #:** _____
Gender: ☐ Male ☐ Female ☐ Prefer not to say ☐ Other_____
Assigned Sex at Birth: ☐ Male ☐ Female
Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____
Country of Origin: _____
Is English your primary language? ☐ Yes ☐ No

- If not, what is your primary language? _____

Address: _____
Phone Number: _____
Email Address: _____
Emergency Contact Name: _____
Relationship to Patient: _____
Emergency Contact Phone: _____
Previous Doctor/Nurse Practioner:_____

2. Past Medical History

List all medical conditions:

_____
_____
_____

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, please provide details (reason, date):

_____

Have you ever had surgery? ☐ Yes ☐ No
If yes, please list (type of surgery, date):

_____
_____

Do you have any allergies? ☐ Yes ☐ No If yes, please also specify reaction.

Medications: _____

Food: _____

Environmental: _____

3. Medications

Are you currently taking any prescription medications? ☐ **Yes** ☐ **No**
If yes, please list below:

Name of Medication	Dosage	Frequency	Reason for Taking

1. _____

2. _____

3. _____

4. _____

5. _____

Are you currently taking any over-the-counter medications, supplements, or herbals? (e.g. Tylenol, Advil, creatine, multivitamins, St. Johns Wort) ☐ **Yes** ☐ **No**
If yes, please list below:

_____

_____

4. Social History

Smoking History: ☐ Current smoker ☐ Former smoker (date quit:_____) ☐ Never smoked
If current/former smoker, how many cigarettes/day? _____ For how many years? _____

Alcohol Use: ☐ Yes ☐ No
If yes, on average, how many drinks per week? _____

Other Subtance/Drug Use: ☐ Yes ☐ No ☐ Current ☐ Former ☐ Never
If current/former please specify: _____

Caffeine Use: ☐ Yes ☐ No
If yes, how many cups per day? _____

Exercise Habits: Type: _____ Frequency: _____

Diet: ☐ Balanced ☐ Unbalanced ☐ Specific diet (e.g., vegetarian, keto): _____

Occupation: _____

Marital status (name and age of partner, if applicable):

_____

Children (name and age): _____

Who do you live with? _____

- ☐ House ☐ Apartment ☐ Own ☐ Rent

5. Family Medical History

Please indicate if your **Immediate** family members have had the following conditions.

Condition	Family Member (i.e. mother, father)	Age at diagnosis	Deceased (Y/N)	Additional Details (e.g. type of cancer)
Diabetes				
Heart Disease				
High Blood Pressure				
Cancer				
Stroke				
Mental Health Disorders				
Other:_____				

6. Gynecological Health (If applicable)

Are you currently pregnant or planning to become pregnant? ☐ Yes ☐ No

Last menstrual period: _____ **Age of first period:**_____

Describe your periods - regular/irregular, heavy, light, and for how many days:

_____

_____

Do you use contraception? ☐ Yes ☐ No
If yes, what type? _____

7. Preventive Care/Health Screening

Vaccination History (check all that apply):
☐ COVID-19 ☐ Influenza ☐ Tetanus ☐ Pneumovax
☐ Shingles ☐ Other: _____

Screenings (indicate the date of the last screening):

- Bloodwork: _____
- Colonoscopy/FIT test: _____
- Pap smear/HPV swab: _____
- Mammogram: _____
- Bone density scan: _____

8. Additional Information

Is there anything else you'd like us to know about your health?

_____

_____

_____

_____

AMIN MOUSAVI, M.D. INC
BABAK PARSI, MD.
MARIA FARAG, M.D.
FARIBA MALEKI, M.D.
NATASHA NUCERA, NP
SUMMER RVELEY, NP
SARA RUIZ, NP

Westgate Medical Clinic
402 20395 Lougheed Hwy
Maple Ridge BC, V2X 2P9
Telephone: 604 465 3900
Fax:: 604 465 3990

Date: _____
Previous Doctor's Name: _____
Phone: _____
Fax: _____

REQUEST FOR MEDICAL INFORMATION

NAME(S): _____

DATE OF BIRTH(S): _____

PHN: _____

The above named patient(s) is/are now attending our medical office. We would appreciate a CD of pertinent information bloodwork, x-rays, consults, hospital admissions and discharge reports, would be sufficient.

Thank you for your help.
Sincerely yours,

( )Dr.B. Parsi, ( ) Dr.A.Mousavi, ( ) NP.S. Reveley, ( )NP. N. Nucera, ( ) F.Maleki , ( ) M. Farag, ( ) NP. S. Ruiz

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Authorization for release of medical information

I hereby authorize any physician, practitioner, hospital or clinic by whom or where I have been observed or treated for any reason to give full particulars thereof, including prior medical history.

I understand that this services is not recognized as a "medically required service" and is not covered by my medical plan. I realize that there may be a charge for this service and that I am responsible for it. Please forward the bill for the service of preparing this report to me for my prompt attention.

Signature of Patient: _____

AMIN MOUSAVI, M.D.
MARIA FARAG, M.D.
BABAK PARSI, M.D.
FARIBA MALEKI, M.D.
SUMMER REVELEY, N.P.
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Westgate MEDICAL CLINIC

#402 – 20395 Lougheed Hwy
MAPLE RIDGE, B.C. V2X 2P9
TELEPHONE: 604-465-3900
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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Westgate Medical Clinic Physicians reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may results in termination from our practice.
Thank you for your understanding and cooperation, as we strive to best serve the needs of all of our patients.

Prescription Refills Policy

Please remember that an appointment is required for all refill prescriptions.
All patients need to contact the office 2-3 weeks prior to running out in order to book an appointment.

It is your responsibility to keep track of your medications and when they will run out, or you may be directed to call your pharmacy for an emergency supply until the next available appointment with your physician.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____
Printed Name

_____
Signature

_____
Date

Patient Informed Consent

Notice:

Before we proceed with your appointment, I want to inform you about an important aspect of how we document our consultations. We utilize a note taking tool called Heidi to accurately and efficiently capture the details of our discussions and the outcomes of our appointments. Heidi ensures that we can focus more on our conversation and less on manual note taking, enhancing the quality of care you receive.

Your consent is crucial for us to use this technology. Please understand that your information will be handled with the utmost care, and Heidi's use is aimed solely at improving your healthcare experience.

What you need to know

1. Purpose of Heidi

- Heidi is used to assist with documenting your consultation, capturing only what is necess-ary for accurate medical records.
- Heidi supports but does not replace your clinician's professional judgment. All medical decisions are made solely by your clinician.

2. Purpose of Heidi

- Your data is processed and stored in your jurisdiction and in accordance with applicable privacy laws.
- None of your data is used for secondary purposes.
- Data is undergoes a rigorous de-identification process to remove personal identifiers.
- Data is handled securely, with encryption and regular audits to ensure compliance.

3. Your rights:

- You can choose to opt-out of the use of Heidi during your consultation.

By signing this consent form, you acknowledge that:

1. You have been informed about the use of Heidi and its purpose.
2. You understand how your information will be handled, stored, and protected.
3. You agree to allow your clinician to use Heidi to assist with documenting your consultation.
4. You understand that you can withdraw your consent at any time without affecting the quality of care you receive.

Name: _____ **Date:** _____

Signature: _____

For more information visit heidihealth.com

CANADA

heidi

How does it work?

Heidi is a helpful tool that allows your clinician to focus entirely on you during your visit while still allowing them to accurately capture medical information, ensuring a comprehensive and precise record of your care.

Do I have to give consent?

Your consent is crucial. All clinicians are encouraged to obtain consent before using Heidi. You can withdraw your consent at any time.

Who has access to my medical information?

Only your clinician! Heidi is compliant with PIPEDA as well as all relevant provincial privacy legislation across Canada and our information management systems are ISO27001 accredited for data security. Your data protection is our top priority.

Where is my data stored?

We prioritise data sovereignty by ensuring all our data is locally hosted within Canada. This practice enhances data security while also ensuring compliance with Canadian data protection regulations.

How is my data used?

Our approach to data collection is threefold:

- **Be Transparent:** We clearly explain how we use your data in our Privacy Policy and Terms and Conditions.
- **Limit Collection:** We only collect data that is essential for providing you our services or enhancing Heidi's effectiveness.
- **Ensure Security:** We restrict the disclosure, retention, and use of your data, ensuring it is safeguarded.

Our commitment ensures that every piece of information collected has a clear purpose, either to deliver the product you love or to improve Heidi's performance and accuracy

Do you store recordings of my appointment?

Conversations are transcribed simultaneously while they happen, meaning no recordings are ever stored. Notes that a clinician saves from the appointment will be added to your Electronic Health Record in your clinician's Practice Management System, as standard.

Any questions?

Get in touch at hello@heidihealth.com or visit heidihealth.com

CONSENT TO USE VIRTUAL CARE TOOLS

This template is intended as a basis for an informed discussion. If used, physicians should adapt it to meet the particular circumstances in which virtual care tools will be used with a patient. Consideration of jurisdictional legislation and regulation is strongly encouraged.

PHYSICIAN INFORMATION:

Name: WESTGATE MEDICAL CLINIC

Address: #402 – 20395 LOUGHEED HWY, MAPLE RIDGE BC, V2X 2P9

Email (if applicable): patient-info@westgatemedical.ca

Phone (as required for Service(s)): 604 464 3900

Website (if applicable): www.westgatemedical.ca

The Physician has offered to provide the following means of virtual care ("the Services"):

(Yes/No) Email	(Yes/No) Videoconferencing
(Yes/No) Text messaging (including instant messaging)	(Yes/No) Website/Portal
(Yes/No) Social media (specify):	
(Yes/No) Other (specify):	

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 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 when interacting 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 in relation to patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for virtual care tools, it is possible that interacting with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to interact 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 using 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 (if applicable):

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

Patient signature:	Date:
Witness signature:	Date:

APPENDIX

Risks of using virtual care tools

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 virtual care tools). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of all virtual care tools:

- Use of virtual care tools to discuss sensitive information can increase the risk of such information being intercepted by third parties.
- Despite reasonable efforts to protect the privacy and security of information communicated through virtual care platforms, 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.
- Virtual care tools can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Communications through virtual care tools 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.
- Communications through virtual care tools may be disclosed in accordance with a duty to report or a court order.
- Some videoconferencing platforms may be more open to interception than other forms of videoconferencing.

If the email or text is used as a virtual care 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 electronic communications such as emails, text messages, and instant messages, 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.
- Virtual care 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 or recordings of virtual encounters 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 and recordings.
- The Physician may forward electronic communications or recordings 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 or recordings 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:
  - ( ) Sexually transmitted disease
  - ( ) AIDS/HIV
  - ( ) Mental health
  - ( ) Developmental disability
  - ( ) Substance abuse
  - ( ) Other (specify):
- 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.

Patient initials_____

APPENDIX CONTINUED

Instructions for using the Services:
To use the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Conduct virtual care encounters in a private setting and using a secure device, where possible.
- Obtain the Physician's consent prior to making any recording of the virtual care encounter.
- 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: *(patient to initial)*

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

Patient signature

Date

Patient initials_____

AMIN MOUSAVI. M.D.
BABAK BEHZADI-PARSI. M.D.
MARIA FARAG, MD
FARIBA MALEKI, M.D
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#402 – 20395 Lougheed Hwy
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FAX: 604-465-3990

Office Policy

1. Please be respectful and kind to our staff. We are all doing our best. If there are any incidents or any form of abuse, including verbal abuse, this may be ground to terminate the patient-provider relationship. We all deserve respect. There will be no warnings. Initial_____.

2. The clinic may contact you directly via text or email as for appointment notifications, lab requisitions etc. Do not reply to these messages. Replies, including medical questions, will not be answered by the office. Please call the office instead. Initials_____.

3. Your Doctor or Nurse Practitioner provides in-person and telehealth appts. on specific days. It is up to you to choose in which method you prefer to conduct your health care visits. Appointments must be booked over the phone. Initials_____.

4. With some exceptions, maximum 1 problem per visit to respect patients' appointments after you. Renewal of prescriptions do not count. Procedures (including pap smears for cervical cancer screening) and medical forms are full visits and therefore do not provide time for additional issues. Initials_____.

5. Please note that fees apply for the completion of medical forms. We accept payment by debit/credit card, cash or cheque. Initials_____.

6. If you are more than 10 minutes late to your appointment, you may have to reschedule and if the providers agree to see you, your appointment might be cut short. There is a $50 no-show fee and if this happens more than 3 times, this may be grounds to terminate the patient-provider relationship. Initials_____.

7. There are appointments available for same day URGENT concerns such as UTI's, sore throats, cough, urgent matters. You will be given an appointment if your concern is deemed urgent and there is space in the providers schedule. If we are unable to accommodate you in office, we encourage you to attend a walk-in clinic, urgent care of if needed the emergency department. You will not be seen on the same day for prescription refills or

chronic on-going concerns. Please book a future appointment for non-urgent concerns. Initials_____.

8. If you have chronic health issues, are on regular pain medications or being treated for ADHD, you must request to book regular follow ups only with your own primary care provider. Plan accordingly. Initials_____.

9. If you have medications that you take regularly, please make efforts to arrange prescription refill appointment at least 3 weeks in advance. If you have found that you have run out and there no appointments, you are encouraged to attend your pharmacy and ask the pharmacist to send us a request by fax. One refill will be granted in this fashion, a second will not and you must book an appointment either in person or via telephone prior to your next refill. Plan accordingly. Initials_____.

10. We will typically only phone for abnormal blood test results unless otherwise specified by your primary care provider. If you want to ensure follow up on results or have not heard from us, you must arrange an appointment to follow up after your tests. Initials_____.

11. If you had recent imaging such as x-ray or US and have not heard from your provider, likely no follow up is needed. If you are concerned regarding your results and want to discuss them further, please make a follow-up appointment one week or more following your test. Initials_____.

12. Sometimes, it may be the case that your primary care providers phones you without an appointment. If we are unsuccessful in connecting with you, we will leave a voice mail. Please do not be alarmed if we phone you for the rest results, except a possible call. Typically, we will only phone for abnormal test results, but there are exceptions to this and may be provider dependent. Initials_____.

13. While we encourage and value multi-disciplinary care to achieve your best health outcomes, we ask that you refrain from asking us to order bloodwork for you Naturopathic Doctor. As a provider it is our duty to follow up with any results and this creates confusion over who is responsible and what blood test were ordered. We kindly ask that any tests that are requested through your ND be ordered, interpreted, and paid for through their office, no exceptions. Initials_____.

14. Please do not "shop" for a GP. There is a lack of family practice providers locally and this is exacerbated by patients who consume multiple of overlapping and redundant resources. If you would like to pursue other avenues of obtaining your primary care, please let us know so we are aware of a plan moving outside of the Fraser Valley and are unable to attend in clinic visits, we ask that you find a new provider locally and inform our office. Initials_____.

By signing this document, I confirm that I have read and understood the above policies and will make efforts to adhere to these clinic policies unless otherwise agreed upon.

_____

Name

_____

Signature

_____

Date