ANCRON MEDICAL CENTRE

Patient Consent & Acknowledgement Form

By signing this form, you confirm that you have read and understood the information provided by Ancron Medical Centre regarding office policies, communications, and consent. The document is available in full at www.ancronmedical.com

Key Information:

- Office Hours: Monday–Friday 8:30 am – 4:00 pm (Closed from 12pm - 1pm and all statutory holidays).
- Phones: Answered 9:00 am – 12:00 pm and 1:00 pm – 4:00 pm.
- Appointments: Visits are generally 10–15 minutes. Urgent needs may be accommodated as available. Please give 24 hours' notice for cancellations to avoid a $45 no-show fee. Patients arriving more than 10 minutes late may need to be rescheduled.
- Prescriptions: Refills require an appointment. Please book 3–4 weeks before running out.
- Results: We will **do our best** to contact you if results are abnormal. Please follow up if you have concerns.
- Forms & Non-insured Services: Many forms/letters are not covered by MSP and must be paid for before completion. Allow up to 30 days for processing.
- Virtual Care Tools (Appendix B): Email, text, phone, and video may be used with your consent. These carry privacy and security risks.
- AI Scribe (Appendix C): May be used to help with note-taking during visits, with your consent.
- Zero Tolerance Policy: Abusive or violent behaviour will result in denied service and possible permanent dismissal from the practice.

Your Consent

Please initial beside each statement:

_____ I have read and understood the clinic's appointment, prescription, and results policies.

_____ I understand that fees may apply for forms, notes, and services not covered by MSP.

_____ I understand the clinic's zero tolerance policy.

_____ Should my contact information change, I will inform Ancron Medical Centre within 30 days.

Please check Yes or No:

I consent: ☐ Yes or ☐ No to the use of AI Scribe technology during my visits.

I consent: ☐ Yes or ☐ No to the use of virtual care tools as outlined (email, text, video, phone)

If there is any sensitive information you **do not** want communicated via Email, Text, Phone or Video please let us know: [ ]Sexually transmitted disease [ ]AIDS/HIV [ ]Mental health [ ]Substance abuse [ ]Developmental disability [ ]Other, specify:_____

Patient Acknowledgement

By signing below, I confirm I have read, understood, and agree to abide by the policies of Ancron Medical Centre. I understand that I may ask questions about this document at any time.

Date: _____

Patient Name: _____ **Signature:**_____

If patient is underage or unable to sign:

Name of Parent/Guardian/Legal Representative: _____

Signature: _____

We respectfully acknowledge our clinic is on the traditional, unceded territory of the Ktunaxa, Syilx, and Sinixt Peoples.