



# **GROWN BLOSSOM**

## **Paediatric Clinic**

**Zil-e-Huma Sheikh MD DABP FAAP**

1671 Howard Ave  
Windsor, ON N8X 3T6  
Ph: 519-256-4040  
Fax: 519-258-2020  
Website: [grownblossom.ca](http://grownblossom.ca)

### **Patient Rights and Responsibilities**

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

#### ***You have the right to:***

- Competent, considerate and respectful health care, regardless of race, creed, religion, age, sex or sexual orientation.
- The personal review of your own medical records by appointment and in accordance with applicable Provincial and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan. This may include referrals to other specialists as needed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.

#### ***You are responsible for:***

- Providing a list of physicians who are active members of your healthcare team or “circle of care” where consultation recommendations may be communicated. Reviewing any changes to this list with each appointment. Specifying if some physicians should NOT get consultation recommendations.
- Keeping the clinic informed about surrogate decision makers, healthcare power-of-attorneys and name and contact information for people to whom your healthcare information may be disclosed.
- Maintaining common sense steps to keeping your healthcare information confidential – understanding privacy implications of unencrypted electronic communications such as regular email or SMS, double checking mailing address when posting mail, verifying the fax number when faxing records, etc.
- Signing a “Release of Information” form when asked so your clinician can get medical records from other clinicians involved in your care.
- Giving your clinical team correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations. This information should include all prescription medication(s), as well as alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician. This includes keeping your OHIP information up to date with the clinic. Inaccurate information can result in rejection by insurance and an invoice directly to you.
- Telling your physician about any changes in your condition or reactions to medications or treatment.
- Asking your physician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your physician’s advice. If you refuse treatment or refuse to follow instructions given by your physician, you are responsible for any medical consequences.

**Initial here:**

- Going to urgent care or your local emergency room for emergent matters that cannot wait until your next appointment. The physician will not be available after-hours, to take same-day phone questions and phone-lines will be answered by staff during business hours only. Please do not call before 8 AM or after 4 PM. Every effort will be made to answer back voicemails within 24-48 business hours. If your matter can wait, please schedule a formal followup appointment to discuss your questions with the physician directly.
- Following up with your family physician or local walk-in clinic or pre-arranged backup physician where the case may be when the doctor is away on hospital duty, vacation, sick-leave, etc. if your matter is semi-urgent and cannot wait until the doctor returns.
- Coming to clinic by appointment only. We do not take walk-ins.
- Discussing lab results and medication refills by appointment. Medications cannot be refilled if your last visit was more than 6 months ago. Labs cannot be reviewed outside of a formal appointment.
- Keeping your appointments. If you must cancel your appointment, please call the clinic at least 24 hours in advance. Missed appointments and cancellations within 24 hrs due to non-emergent reasons incur a re-booking fee. No further appointments can be booked unless this fee is paid. Scheduling reminders may be offered as a courtesy only – you are ultimately responsible to setup a reminder system that is suitable to you (eg. calendar app or alarm on your phone, etc.)
- Paying co-payments/co-insurance if applicable at the time of the visit or other bills upon receipt. In particular, non OHIP covered services such as physician statements for insurance, disability paperwork, sick notes, photocopying of documents or faxing large quantities of medical records, Assistive Devices Program paperwork, etc. will be charged in accordance with the Ontario Medical Association Schedule of Fees for Uninsured Services.
- Understanding that care may be delivered in conjunction with trainees – such as medical students or residents under attending supervision. Patients have the right to refuse.
- Understanding that all private exams for patients regardless of gender,  $\geq 12$  years of age MUST be chaperoned by clinic staff. Parental chaperones are acceptable for children 0-11 years of age.
- Acting responsibly with controlled drugs prescribed (eg. Adderall, Ritalin, Concerta, Testosterone, HCG, Growth Hormone, etc.) – diversion, obtaining simultaneously from other physicians, mixing with other illicit drugs or taking these not as prescribed will not be tolerated. Periodic drug screens may be done to enforce compliance.
- Having details of your child's medical records transmitted to the clinic from their family doctor or other specialist when these are needed. Eg. growth charts, immunization history, etc.
- **ALL Diabetic patients:** concurrent active followup with the Paediatric Diabetes/Metabolic Program, Windsor Regional Hospital between doctor's appointments, bringing your glucometer and glucose logbooks to the office for review, uploading insulin pump/continuous glucose monitor data to the relevant manufacturer's portal (Libreview for Libre CGMs, Carelink for Medtronic devices, Glooko for tslim and Omnipod pumps and Dexcom CGMs) prior to your appointment, keeping updated on your ADP paperwork as needed with the help of Paediatric Diabetes Program at WRH, taking steps to stay current with recommended vaccines, eye exams, foot exams and labwork prior to appointments.
- Ensuring **transfer of care requests** from a specialist come directly from the specialist with all appropriate background records (eg. if the specialist is retiring, etc.).
- Following the office's rules about patient conduct. Smoking, alcohol, drugs and weapons are not allowed on or around the premises. Public health regulations in effect (eg. such as in a pandemic situation) are to be followed.
- Respecting the rights and property of our staff and other persons in the office. Verbal or physical aggression, epithets, slurs, threats and sexual harassment will not be tolerated and will be reported to authorities.
- Refusal to follow your physician's advice, not respecting clinic policies, repeated missed appointments and or improper behavior with clinic staff & the doctor may be grounds for dismissal from the practice. Your family physician may refer you to an alternative physician for consultation if clinically warranted.

**I FULLY UNDERSTAND AND AGREE TO THE ABOVE**

Patient Name:	Guardian:	
DOB yyyy-mm-dd	Signature:	Date:



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### AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION TO A REPRESENTATIVE

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying the medical practice in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the medical practice in reliance on this authorization. I understand that the provision of treatment or health care may not be conditioned on my providing this authorization. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the provincial/federal privacy regulations.

Description of the information to be used or disclosed:

☐ All information

☐ Specific information below only:

The persons to whom the medical practice is authorized to make the disclosure:

NAME	RELATIONSHIP	PHONE NUMBER	ADDRESS

**Name of Patient:**

**Date of Birth yyyy-mm-dd:**

**Guardian/Parent/Power-of-Attorney:**

**Signature:**

**Date:**

**Address:**

# Governing Law and Jurisdiction Agreement

## for physician in private practice

This agreement ("Agreement") is entered into by and between \_\_\_\_\_ and  
[Name of patient]  
**ZIL-E-HUMA SHEIKH MD** (collectively, the "Parties").  
[Physician in private practice]

### Governing Law

The Parties hereby agree that:

- a) all aspects of the relationship between \_\_\_\_\_ and  
[Name of patient]  
**ZIL-E-HUMA SHEIKH MD** (as well as her/his agents, delegates, employees, and any  
[Physician in private practice]  
physicians and other independent healthcare practitioners providing medical or other healthcare and  
treatment to \_\_\_\_\_, or in association with **ZIL-E-HUMA SHEIKH MD**),  
[Name of patient] [Physician in private practice]  
including without limitation any medical or other healthcare and treatment provided to  
\_\_\_\_\_, and  
[Name of patient]

- b) the resolution of any and all disputes arising from or in connection with that relationship, including any  
disputes arising under or in connection with this Agreement,

shall be governed by and construed in accordance with the laws of the province or territory of **ONTARIO**  
[Province or territory]  
(other than conflict of laws rules) and the laws of Canada applicable therein.

### Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by  
\_\_\_\_\_ from **ZIL-E-HUMA SHEIKH MD** will be provided in the  
[Name of patient] [Physician in private practice]  
province or territory of **ONTARIO**, and that the Courts of **ONTARIO**  
[Province or territory] [Province or territory]  
shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising  
from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship  
between \_\_\_\_\_ and **ZIL-E-HUMA SHEIKH MD**.  
[Name of patient] [Physician in private practice]

Date: \_\_\_\_\_

\_\_\_\_\_  
Name of patient [Please print]

\_\_\_\_\_  
Signature of patient / substitute  
decision-maker on behalf of patient

Date: \_\_\_\_\_

**ZIL-E-HUMA SHEIKH MD**  
\_\_\_\_\_  
Name of physician in private practice [Please print]

\_\_\_\_\_  
Signature of physician in private practice



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### CONSENT TO USE VIRTUAL CARE TOOLS OR ELECTRONIC COMMUNICATIONS

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

One-way SMS Text messaging from clinic-to-patient to provide scheduling notices/appointment reminders	Website at GrownNBlossom.ca for downloadable forms or other general updates from the clinic
Telephone Consultations	Video consultations on OTN.ca (Ontario Telemedicine Network)
Video consultations on end-to-end encrypted platforms such as meet.jit.si or using the jitsi app <a href="https://jitsi.org/downloads/">https://jitsi.org/downloads/</a>	Ontario eConsults Program ( <a href="https://otn.ca/patients/econsult/">https://otn.ca/patients/econsult/</a> )

### 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. It is my responsibility to keep my phone number and/or email address updated with the clinic if there are any changes required to this form. Any questions I had have been answered.

Patient name:

Patient address:

Patient mobile phone:

Patient mobile phone carrier:

Patient email (if applicable):

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

Patient signature:

Date yyyy-mm-dd:

## 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:
  - (Yes/No) Sexually transmitted disease
  - (Yes/No) AIDS/HIV
  - (Yes/No) Mental health
  - (Yes/No) Developmental disability
  - (Yes/No) Substance abuse
  - (Yes/No) 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)*

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

---

Patient signature

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Date yyyy-mm-dd

Patient initials\_\_\_\_\_

**Release of Information aka Consent to Disclose Personal Health  
Information Form**  
**Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Print your name) (Print name of health information custodian )

**to disclose**

☐ my personal health information

**or**

☐ the personal health information of \_\_\_\_\_  
(Name of person for whom you are the substitute decision-maker\*)

consisting of (check mark which is applicable):

Medical Summary	Imaging Reports	Imaging CD	Lab reports
Entire Medical Chart	Last encounter note	First encounter note	Immunization Records
Cumulative Patient Profile	Discharge Summary	Transfer Note	Growth Chart
Other (describe below)			

**to ZIL-E-HUMA SHEIKH MD, Grow N Blossom Paediatric Clinic, 1671 Howard Ave,  
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Ph: 519-256-4040, Fax: 519-258-2020**

**I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form. I understand that there may be a fee I have to pay to comply with my request and am willing to pay any applicable fees to the sender directly.**

**My Name:**\_\_\_\_\_ **Address:**\_\_\_\_\_

**Home Tel.:**\_\_\_\_\_ **Work Tel.:**\_\_\_\_\_

**Signature:**\_\_\_\_\_ **Date:**\_\_\_\_\_

**\*Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**





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### **NEWBORN**

#### **PATIENT HEALTH INFORMATION SUMMARY & INTAKE FORM**

Name (Last name, First name)	
DOB (yyyy-mm-dd)	
Address	
Emergency contact, relationship and phone number	
Family Doctor/Referring Doctor	
Pharmacy with address and phone number	
OHIP no. with version code	
OHIP card expiry date (yyyy-mm-dd)	
Secondary/Other insurance name and	

policy number	
Drug insurance name	
Do you pay for medications out-of-pocket?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	
Birth History	<p>When was your baby born (how many weeks)?</p> <p><input type="checkbox"/> Vaginal    Any complications?</p> <p><input type="checkbox"/> C-section    Why?</p> <p>Any complications?</p> <p>GBS positive? <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> I don't know</p> <p>Birth Weight?</p>
Prenatal History	<p>Did patient's mother take any medications during pregnancy? <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If so, please list which ones?</p> <p>Did patient's mother take any of the following during pregnancy: (If yes to any of the following, please indicate how often in a week)</p> <p>Alcohol    <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Illicit drugs   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Did your baby stay in the NICU?	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If Yes, how long (days or weeks)?</p> <p>Any Complications?</p>

	<p>Was your baby sent home with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list below:</p>		
List medical diagnoses	Diagnosis	Year of Onset	Name of Specialist following if applicable
List past or upcoming surgeries.	Surgery		Year
Active medications/supplements	Medication name	Dose	Frequency
Please list all members your baby lives with (please include pets)			
Any smokers in household?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list occupation of caregivers.			

Family History of Medical Problems	Father: Mother: Sibling(s): Paternal Grandfather: Paternal Grandmother: Maternal Grandfather: Maternal Grandmother: Any history of consanguinity in parents? <input type="checkbox"/> Yes <input type="checkbox"/> No Any history of genetic disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, please describe:

**Name of Patient:**

**DOB:**

**Guardian/Parent/Power-of-Attorney:**

**Signature:**

**Date:**

**Address:**