



WELCOME NEW TELEMEDICINE PATIENTS!

Clinic Overview

This clinic was founded in 2006 as a way to enhance the care provided under the public health care system in Canada. We have evolved into a specialty treatment center providing highly promising scientifically rational therapies that are generally not available through hospitals or oncologists for various administrative, financial or political reasons. We only provide therapies that are legal to use in Canada, and we do not provide therapies that have been proven to be ineffective. We have treatments available for **all cancer types**, and we treat patients of **all ages**.

We have observed that there are many health care practitioners who treat cancer in different ways. Our experience indicates the best outcomes often result from a combined approach in which conventional medicine is used along with non-traditional or natural therapies. As a result, our Medical Director Dr. Akbar Khan (M.D.) now exclusively provides **“integrative care”** in conjunction with qualified naturopathic doctors (N.D. or equivalent).

We also recognize that naturopathic doctors specializing in cancer are not readily available in every country, or even in every part of Canada. Therefore, for telemedicine patients, we recommend you consult with a qualified naturopathic doctor (N.D. or equivalent), but it is not required.

Booking a Telemedicine Consultation

This New Patient Package must be completed and submitted to our office (by fax / mail / email or in person). It will also be very helpful if some medical reports can be included (if applicable): pathology report, latest blood test report, latest scan report, doctor's recent consultation note or doctor's summary note.

These can be obtained from your oncologist, family doctor, naturopathic doctor or hospital Medical Records Office.

PLEASE COMPLETE ALL THE DOCUMENTS IN THIS PACKAGE AND FORWARD TO US ALL TOGETHER WITH YOUR MEDICAL REPORTS.

Sending forms one at a time will delay your consultation.

Contact Information

Address: 4576 Yonge St, Suite 301, Toronto, M2N 6N4

Phone: 416-227-0037

Fax: 416-227-1915

Email (administrative liaison Yasmine Ibrahim): yibrahim@medicorcancer.com

Email (office manager Silvana Marra): smarra@medicorcancer.com

Checklist for Telemedicine Consultation

- Patient Questionnaire completed and signed
- Medicor General Consent reviewed and signed
- Email Policy reviewed and initialed
- Fees List reviewed
- Payment Authorization completed and signed
- Governing Law Agreement signed (ONLY FOR PATIENTS OUTSIDE CANADA)

Helpful Reports to Include:

- Copy of latest blood test report, if applicable
- Copy of latest scan report(s), if applicable
- Copy of pathology report(s), if applicable
- Copy of recent doctor's consultation note or doctor's summary note

We look forward to assisting with your care and treatment!

Sincerely,

The Medicor Team



MEDICAL QUESTIONNAIRE

To complete on the computer: please use free Nuance PDF Viewer in order to fill and save: <http://www.nuance.com/for-business/by-product/pdf/pdfreader/index.htm>

PERSONAL INFORMATION	
First Name: _____	Last Name: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Wid. <input type="checkbox"/> Other _____	
Street: _____	Unit # _____
City: _____	State/Prov: _____ Country: _____
Postal Code: _____	
Home phone: _____	Work Phone: _____
Cell phone: _____	Fax number: _____
5. Email address: _____	
6. Date of birth: (day/month/year) _____	
7. Health card number: _____ VC: _____ Health card province: _____ (for Canadian patients only)	
8. Do you have private health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
9. Who should be contacted in case of emergency?	
Name: _____	Relationship: _____
Contact numbers: _____	
10. Second language (optional): _____	
11. Religion (optional): _____	

Revised Feb 4, 2014

CANCER HISTORY

What type of cancer do you have?

How was it diagnosed?

Diagnosis date:

Was a biopsy obtained? Yes No Not sure

What treatments have you received?

Chemotherapy Yes No Not yet, starting soon Not sure

Radiation therapy Yes No Not yet, starting soon Not sure

Surgery Yes No Not yet, starting soon Not sure

Experimental therapy Yes No Not yet, starting soon Not sure

Natural therapy Yes No Not yet, starting soon Not sure

PAST MEDICAL HISTORY

Do you have (or have you ever had) any of the following? *(check only if yes)*

Disease		√	About when was it diagnosed?
Cardiovascular disease	High blood pressure	<input type="checkbox"/>	
	Angina	<input type="checkbox"/>	
	Heart attack	<input type="checkbox"/>	
	Congestive heart failure	<input type="checkbox"/>	
	Abnormal heart rhythm	<input type="checkbox"/>	
	Blood clot (DVT)	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Lung disease	Asthma	<input type="checkbox"/>	
	Bronchitis/Pneumonia	<input type="checkbox"/>	
	Emphysema	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Kidney disease	Stones	<input type="checkbox"/>	
	Infections	<input type="checkbox"/>	
	Kidney failure	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Liver disease	Hepatitis	<input type="checkbox"/>	
	Jaundice	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Blood disorder	Bleeding problems	<input type="checkbox"/>	
	Anemia	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Neurological problems	Stroke	<input type="checkbox"/>	
	Seizures	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	

PAST MEDICAL HISTORY (continued)

Disease	√	About when was it diagnosed?
Diabetes	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	
Thyroid disease: specify	<input type="checkbox"/>	
Skin disease: specify	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	
Stomach or duodenal ulcer	<input type="checkbox"/>	
Previous cancer	<input type="checkbox"/>	

Do you have any other health problem or have you had any operations?

Other Health Problems / Operations	Approximate date(s)

SOCIAL HISTORY

Occupation

Have you ever smoked cigarettes? Yes No

How long? _____ years

How much? _____ per day

Are you still smoking now? Yes No

Do you drink alcohol? Yes No

If yes, how much?

_____ drinks per day OR _____ drinks per week OR occasionally

Have you ever used recreational drugs? Yes No

If yes:

Please list: _____

ALLERGIES / ADVERSE REACTIONS

Have you ever had an **allergy** or **adverse reaction** to any of the following?

Category	Yes √	No √	Please list
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Foods	<input type="checkbox"/>	<input type="checkbox"/>	
Others (pollen, grass, pets, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY HISTORY

Please provide the following information regarding blood relatives

Relation	List major illness (e.g. diabetes, cancer, ulcers, blood clots, heart, lung, liver, kidney disease)
Father	
Mother	
Sisters	
Brothers	
Children	<input type="checkbox"/> Not applicable How many boys? _____ How many girls? _____
Other	

ECOG PERFORMANCE STATUS

Please indicate your level of activity (check one)	√
Fully active, able to carry on all activities (same as before cancer diagnosis) without restriction.	<input type="checkbox"/> 0
Restricted in strenuous activity but walking and able to carry out light work e.g. office work.	<input type="checkbox"/> 1
Walking and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of the day.	<input type="checkbox"/> 2
Capable of only limited self-care (washing, changing clothes, going to washroom), confined to bed or chair more than 50% of the day.	<input type="checkbox"/> 3
Completely disabled. Cannot carry on any self-care (washing, changing clothes, going to washroom). Totally confined to bed or chair.	<input type="checkbox"/> 4

FUNCTIONAL ENQUIRY

Height: ____ ft ____ in or ____ cm Body weight: ____ pounds kg

Weight Decreasing Stable Increasing

Appetite Decreased Normal Increased

Sleep Decreased Normal Increased

Mood Depressed Normal

Energy level Low Normal High

Do you have any of the following: Check a box (0=none, 10=worst)

Fever 0 1 2 3 4 5 6 7 8 9 10

Chills 0 1 2 3 4 5 6 7 8 9 10

Sweating 0 1 2 3 4 5 6 7 8 9 10

Mouth sores 0 1 2 3 4 5 6 7 8 9 10

Nausea 0 1 2 3 4 5 6 7 8 9 10

Vomiting 0 1 2 3 4 5 6 7 8 9 10

Food sticking when swallowing 0 1 2 3 4 5 6 7 8 9 10

Pain when swallowing 0 1 2 3 4 5 6 7 8 9 10

Constipation 0 1 2 3 4 5 6 7 8 9 10

Diarrhea 0 1 2 3 4 5 6 7 8 9 10

Cough 0 1 2 3 4 5 6 7 8 9 10

Shortness of breath 0 1 2 3 4 5 6 7 8 9 10

Dizziness 0 1 2 3 4 5 6 7 8 9 10

Palpitations (feeling of abnormal heartbeat) 0 1 2 3 4 5 6 7 8 9 10

Limb swelling legs arms 0 1 2 3 4 5 6 7 8 9 10

Facial swelling 0 1 2 3 4 5 6 7 8 9 10

Headache 0 1 2 3 4 5 6 7 8 9 10

Numbness / tingling of hands or feet 0 1 2 3 4 5 6 7 8 9 10

Any other parts of the body? (if yes, please list):

Restlessness 0 1 2 3 4 5 6 7 8 9 10

Confusion 0 1 2 3 4 5 6 7 8 9 10

Memory problems 0 1 2 3 4 5 6 7 8 9 10

Rash 0 1 2 3 4 5 6 7 8 9 10

Bleeding problems 0 1 2 3 4 5 6 7 8 9 10

Urination problems 0 1 2 3 4 5 6 7 8 9 10

Pain 0 1 2 3 4 5 6 7 8 9 10

If yes, what parts of the body? _____

MISCELLANEOUSIs any "conventional" cancer treatment being offered now? Yes NoAre you or do you think you may be pregnant? Not applicable Yes NoAre you receiving nursing care at home? Yes No Not sure

Do you have a "power of attorney" for:

Personal care? Yes (name: _____) No Not sureFinances? Yes (name: _____) No Not sure**HEALTH CARE INFORMATION**

Please provide the following information about your health care providers:

Specialty	Name	Phone Number	Hospital
Family doctor			
Oncologist			
Radiation oncologist			
Surgeon			
Naturopathic doctor			
Other			

Would you like any of your doctors informed about your treatment with us?

 Name: _____ Fax: _____ Email: _____**MEDICOR**

As per Medicor Cancer Centres Privacy Policy, we do not give confidential personal information over the phone. If such a request is made, we may require correct answers to some questions before giving out any information. This is only for your protection. In order to do this, please provide answers to the following questions:

a. Place of birth _____

b. Mother's name _____

c. Favourite colour _____

How did you find out about Medicor Cancer Centres?
_____*Thank you for providing this information. Please sign and date below.***Signature:** _____**Date:** _____



Fees List

updated Mar 2016

Medical Doctors' Services – medical services are taxable (add 13%)	Cost
Phone / fax / email a repeat prescription (up to 3 drugs)	\$28
Phone / fax / email a new prescription, includes assessment	\$83
Phone / fax / email copies of test results at patient's request	\$23
Phone / email / telemedicine assessment and medical advice (non-urgent)	\$56 and up ¹
Phone discussion with patient's other doctor(s), at patient's request	\$56 and up ¹
Forms completion	\$40 and up
Research into specific treatments (by patient request) ²	\$56 and up ¹
Disability Tax Credit form	\$100
CPP Disability Benefits application	\$150
Telemedicine Consultation (3 - 10 day turnaround time)	\$499
Telemedicine Consultation, Rush (2 day turnaround time)	\$709

1 - Billed at a rate of \$499 per hour of physician time (minimum \$56 per service).

2 - Canadian patients: research can be done at no charge during office visits, strictly limited by available appointment time.

Naturopathic Doctors' Services – medical services are taxable (add 13%)	Cost
Time-based service (per 15 minutes)	\$52.50
Standard 60 min. Consultation (first visit or telemedicine consultation)	\$210
Follow up visit	\$52.50 and up ³
Phone or email assessment and medical advice (non-urgent)	\$20 and up ⁴

3 - Billed at a rate of \$210 per hour of naturopathic doctor time (minimum \$52.50 per service).

4 - Billed at a rate of \$210 per hour of naturopathic doctor time (minimum \$20 per service).

Medications – * indicates taxable item (add 13%)	Cost
DCA oral 500mg caps or 200mg/ml oral liquid, per 1 week supply	\$200
DCA iv, 250mg/ml x 30ml (7500mg), 1 vial	\$136
R-alpha lipoic acid 150mg x 90 caps, 1 bottle	\$40*
Acetyl L-carnitine 500mg x 120 caps, 1 bottle	\$29*
Benfotiamine 100mg x 120 caps, 1 bottle	\$29*
LDN 1mg x 112 caps, 1 bottle (lasts for approx. 4 – 6 weeks)	\$90
LDN 1mg/ml oral liquid, 4 weeks supply, 1 bottle	\$133
HonoPure 250mg x 120 caps, 1 bottle	\$98*
Vitamin D3 oral liquid, 5000U per 1ml, 100ml bottle	\$34*
A.O.R. Pro Curcumin, 1 bottle	\$69*
A.O.R. Pro Green Tea, 1 bottle	\$32*

Approximate medication prices are shown, please check with the office for most up-to-date pricing.

Intravenous Infusion Therapies – infusions are taxable (13%), but not prescription medicines	Cost
DCA 3000mg (dichloroacetate)	\$189.81
DCA 4000mg	\$207.93
DCA 5000mg	\$226.05
DCA 6000mg	\$244.17
ALA (DL lipoic acid up to 500mg)	\$183.75
PB 6000mg (phenylbutyrate)	\$230.70
PB 12000mg	\$500.70
VITAMIN C (up to 25 grams)	\$167.70
VITAMIN C (26 - 50 grams)	\$215.70
VITAMIN C (51 - 75 grams)	\$263.70
add ALA	\$110.25
add VIT C (up to 25 grams)	\$97.48
add VIT C (26 - 50 grams)	\$142.20
add VIT C (51 - 75 grams)	\$190.20
add PB 6000mg	\$157.20
add PB 12000mg	\$247.20

Rates subject to change without notice.

Please check with office manager for most up-to-date pricing.

Sales tax 13% tax applies to some items.



This form must be completed for patients who wish to receive consultation and/or treatment at Medicor Cancer Centres.

CONSENT AND DIRECTION FOR INTEGRATIVE TREATMENT

I hereby confirm that I have been diagnosed with cancer, and I have elected to receive treatment at Medicor Cancer Centres Inc. ("Medicor") which consists of combined treatment provided by a **medical doctor** (M.D.) working with a **naturopathic doctor** (N.D.). I understand that Medicor requests that I have a naturopathic doctor (or equivalent) assisting with my medical care, but this is not required.

Potential Benefits

I understand that:

- Medicor's integrative treatments may cause slowing or stabilization of cancer growth, shrinking of cancer, or remission of cancer
- Medicor's integrative treatments may enhance the effects of my other cancer treatments (like radiation or chemotherapy) if taken according to the instructions given to me by my doctors
- Medicor's integrative treatments may improve quality of life
- the likelihood of these benefits is unknown
- Medicor may collect information from my treatment to help doctors and patients learn more about the treatment for cancer, and that this information may be used to help future cancer patients
- my privacy will be maintained at all times in this process

Potential Risks

I understand that:

- I will be watched carefully for any side effects
- doctors don't know all the side effects that may happen
- side effects may be mild or serious
- integrative treatments may interact with other medications I am taking, and my doctors will advise me of potential interactions
- integrative treatments may interfere with other cancer therapies if I do not follow the instructions given to me by my doctors

Unknown Side Effects

I understand that:

- integrative treatments may cause side effects which are as yet unknown, and unpredictable
- integrative treatments may not be effective at treating my cancer, but are unlikely to worsen my cancer

Initial_____

Consent for Integrative Treatment, page 1 of 3

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Monitoring for Side Effects

I understand that:

- while receiving integrative treatments I will be monitored to ensure safety, and for effectiveness of the treatment.
- the exact monitoring will depend on the nature of my cancer, my age, my underlying medical conditions, my concurrent medications and other factors

Follow-Up

I understand that while receiving integrative treatments I must be monitored to ensure safety, and for effectiveness. I confirm that I have a local doctor who will be the primary doctor monitoring my treatment according to the treatment plan I receive from Medicor.

General

My decision to receive treatment from Medicor is entirely voluntary. I understand that I may discontinue treatment at any time. I understand that treatment may be stopped if the medical staff so determine that it is in my best medical interests.

I understand that Medicor is owned by a family member of the Medical Director. I understand that any diagnostic tests or treatment provided by the Medical Director and/or Medicor will only be performed for my benefit, and that I have a choice of where I may obtain such diagnostic tests or treatments.

I understand that the results of integrative treatments are not guaranteed. I acknowledge that no guarantee or assurance has been made by anyone from Medicor.

I have been given the opportunity to read this form and to ask any questions I may have. I voluntarily consent to receive integrative treatment from Medicor.

Costs

I understand that I am responsible for the cost of integrative treatment, since the medicines and services provided by Medicor may not be funded by Government Health Insurance and may only be partially funded by Private Medical Insurance. I have read the attached list of **Medicor Fees**. I will also be responsible for the costs of any tests that may be useful for my medical care but are not covered under Government Health Insurance or Private Medical Insurance.

I understand that for any services not on the **Medicor Fees** list, the **naturopathic doctor's time** is charged at **\$52.50 per 15 minutes** (+ tax) as of October 2014. This includes telephone advice and email advice. This rate is subject to change without notice and the current rate will be available on request from the office manager.

I understand that for any services not on the **Medicor Fees** list, the **medical doctor's time** is charged at **\$41.58 per 5 minutes** (+ tax) as of October 2014. This rate is subject to change without notice and the current rate will be available on request from the office manager.

I have read and understand the **Telemedicine and Email Policy**. I understand the risks associated with email communication, and I consent to the conditions outlined in the policy.

Patient's Signature
(or legal substitute)

Printed Name

Date



Telemedicine and Email Policy

At Medicor we are pleased to offer telemedicine / email communications to our patients. Communicating information by email can be very convenient, but it creates some issues which you should be aware of:

- The privacy and security of email communication cannot be guaranteed.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of Medicor or the patient.
- Email senders may accidentally misaddress an email, resulting in it being sent to unintended and unknown recipients.
- Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Emails can introduce viruses into a computer system, and potentially disrupt the computer (Medicor uses anti-virus software on all of its computers).

Medicor will use reasonable means to protect the security and confidentiality of email information sent and received. Due to the issues outlined above, Medicor requests that you understand the following:

- Emails to or from you form part of your medical record, and may be printed or saved electronically by Medicor. Other individuals authorized to access the medical record will have access to those emails.
- Emails may be forwarded internally if necessary to those involved in diagnosis, treatment, reimbursement or health care operations. Medicor will not forward emails to independent third parties without your written consent, except as authorized or required by law.
- Medicor will try to read and respond promptly to emails, but we cannot guarantee that any particular email will be read and responded to within any particular period of time. **You should not use email for medical emergencies or other time-sensitive matters.**
- Email communication is not a substitute for clinical examination. You are responsible for following up on the physician's email and for scheduling appointments with the Medicor doctor or your other doctor(s) when it is appropriate.
- If your email requests or requires a response from Medicor 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 email and when the recipient will respond.
- You should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, mental health, or substance abuse. Similarly, Medicor will not generally discuss such matters by email (there may be rare exceptions).
- You are responsible for informing Medicor of any types of information you do not want to be sent by email.
- Medicor is not responsible for information loss due to technical failures.
- Emails will not be encrypted.

Instructions for Communication by Email

To communicate by email, please do the following:

- Limit or avoid using an employer's computer.
- Inform Medicor of any changes in your email address.
- Include in the email: 1) patient name
2) a description in the email's subject line (e.g., "prescription renewal")
- Review the email to make sure it is clear and that all needed information is provided before sending to Medicor.
- Take precautions to preserve the confidentiality of emails.

Should you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on email. Rather, you should call Medicor for advice or an appointment, call your family doctor or specialist, go to the nearest hospital Emergency Department, or take other appropriate action.

Telemedicine and Email Fees

Email and telemedicine are generally not covered by Government Health insurance in Canada. **Individual services** are available to all patients and are billed according to the list below.

Individual Services	Cost
Phone / fax / email a repeat prescription (up to 3 drugs)	\$23
Phone / fax / email a new prescription, includes limited assessment	\$56
Phone / fax / email copies of test results at patient's request (per report)	\$23
Phone / email / telemedicine assessment and medical advice (non-urgent)	\$56 and up ¹
Phone discussion with patient's other doctor(s), at patient's request	\$56 and up ¹
Forms completion	\$23 and up ¹
Research into specific treatments (by patient request) ²	\$56 and up ¹
Disability Tax Credit form	\$79
CPP Disability Benefits application	\$120

1 - Billed at a rate of \$499 per hour of physician time (minimum \$56 per service).

2 - For Canadian patients: research can be done at no charge during office visits only, strictly limited by available appointment time.

Free Services For Canadian patients only (except Québec)

Some email / telemedicine services are now **free** to the patient (paid by the government):

Free (by email / phone)	Payment Still Required (by email / phone)
Ordering tests and interpreting test results	Assessment of new problems
Arranging for assessments, procedures or therapy	Prescriptions (new or repeats)
Coordinating community and hospital care	
Discussion with and providing advice regarding the above (when medically necessary)	
Supplies and personnel related to all of the above	

Canadian patients may obtain these free services at Medicor if certain conditions are met:

- You have been seen by a Medicor physician in person at least once.
- Your cancer is metastatic or considered incurable (prognosis less than 1 year given by specialist)
- Your Medicor physician is providing ongoing care and treatment (which may include gentle cancer therapies).

Yes, I would like my Medicor physician to be the main physician who is regularly providing quality-of-life enhancing care and treatment. I will still see my own family physician or specialists any time I need to. I meet the conditions listed above and I wish to receive the free services listed in the table above. I have a valid health card from any province in Canada (except Québec). _____ (initial)

No, I already have another physician who is the main doctor providing quality-of-life enhancing care for me. I understand that I may have to pay a fee if I request any of the services in the table above. If I come to the office in person, I can obtain these services at no charge (limited by appointment time) with a valid health card from any province in Canada (except Québec). _____ (initial)

Note: Québec patients are excluded because the Québec government will not automatically pay for their medical care in Ontario. Québec patients are responsible for payment of all medical services up front and may apply to the Ministère de la Santé for reimbursement.



Credit Card / Debit Payment Authorization Form

I authorize Medicor Cancer Centres Inc. (MCC) to charge my:
 VISA MasterCard AMEX bank account via direct debit (attach void cheque)

for the following (in Canadian dollars + 13% tax on medical services and natural supplements):

- MD Consultation** - \$499 (done in 3 - 10 days) **Urgent** (done within 48 hrs) – add \$210
- MD Time-Based Services** (phone, email, research) - \$499 / hour (minimum \$56)
- Naturopathic Doctor Consultation** - \$210.00 (done in 3 - 10 days)

- DCA** (dichloroacetate) 500mg **capsules** (\$200 / week): _____ weeks supply
- DCA** (dichloroacetate) 200mg/ml **oral liquid** (\$200 / week): _____ weeks supply
- DCA** (dichloroacetate) 250mg/ml **liquid for infusion** (\$136 / 30ml vial): _____ vial(s)
- R+ Alpha Lipoic Acid** 150mg x 90 **capsules** (\$40 / bottle): _____ bottle(s)
- Benfotiamine** (vitamin B1) 100mg x 120 **capsules** (\$29 / bottle) _____ bottle(s)
- Acetyl L-Carnitine** 500mg x 120 **capsules** (\$29 / bottle): _____ bottle(s)
- LDN** (low dose naltrexone) 1mg x 112 **capsules** (\$90 / bottle): _____ bottle(s)
- LDN** (low dose naltrexone) 1mg/ml x 112ml **oral liquid** (\$133 / bottle): _____ bottle(s)
- Vitamin D3** 5000U/ 100ml **oral liquid** (\$34 / bottle): _____ bottle(s)

under the terms and conditions agreed to by me with MCC until such time as written notice to the contrary is given. **All medications are non-refundable once dispensed, and consultation services are non-refundable once rendered.**

Credit card number: _____ Expiry date: _____/20_____

Name on the card: _____

Billing address: _____

I consent to disclosure of personal information in this authorization to MCC's financial institution, to the extent necessary. I will notify MCC in writing of any changes in the account information or termination of this authorization 24 hour prior to the next due date of a pre-authorized debit. I agree to pay a fee of \$25 for each transaction that is refused by my financial institution for insufficient funds (NSF). I have read and understood MCC's Refund Policy and Privacy Statement (next page).

Name: _____ Signature: _____ Date: _____

REFUND / CANCELLATION POLICY

If for any reason, you wish to cancel your services, we will gladly offer you a refund based on the following MCC policy.

Consultation services:

In-person Consultation: A full refund will be given if cancellation is made at least 24 hours before the first appointment. Cancellations made with less than 24 hours' notice before the first Consultation appointment will be subject to a \$100 late cancellation fee. If the first Consultation visit has already taken place, no portion of the consultation fee is refundable.

Telemedicine Consultation: a full refund will be given if cancellation is made before the service has been rendered. Once a consultation has been sent to the patient or their representative, no portion of the consultation fee is refundable.

Monthly Care:

Monthly care services can be cancelled any time with 24 hours' notice. No further charges for monthly care will apply once a cancellation request is received. Monthly care services for the current month (calculated monthly from the subscription start date) are not refundable.

Medications:

All medications are non-refundable once dispensed. Medications damaged or lost in transport must be claimed under the insurance of the shipping company.

PRIVACY STATEMENT

We are bound by law and ethics to safeguard your privacy and the confidentiality of your personal health information.

This includes:

- collecting only the information that may be necessary for your care;
- keeping accurate and up-to-date records;
- safeguarding the medical records in our possession;
- sharing information with other health care providers and organizations on a "need to know" basis where required for your health care;
- disclosing information to third parties only with your consent or where required by law; and
- retaining or destroying records in accordance with the law.

Your request for care implies consent for the collection, use and disclosure of your personal information for purposes related to your care. As noted above, other purposes require your express consent.

You have the right to request access to or correction of your health records. Please speak to the receptionist for further information.

It is our standard procedure to send appointment reminders in the mail and/or leave telephone answering machine messages, but you have the right to request that we not do either if you make that request in writing.

If you have any specific questions or concerns regarding the use, collection or disclosure of your personal health information, or would like to contact the Information and Privacy Commissioner of Ontario, please feel free to speak with Dr. Humaira Khan (Medicor CEO).

**Medicor Cancer Centres, 4576 Yonge St. Suite 301, Toronto, ON M2N 6N4
(416) 227-0037 (phone), (416) 227-1915 (fax)**



MEDICATION RE-ORDER FORM

DCA 500mg caps _____ week(s) supply @ \$200 / wk same dose as before new dose per MD

DCA oral liquid 200mg/ml _____ week(s) supply @ \$200 / wk same dose as before new dose per MD

DCA iv 250mg/ml _____ vials of 30ml (each vial is 7500mg) @ \$136 / vial

Benfotiamine 100mg, 120 caps per bottle _____ bottle(s) @ \$29 / bottle

R+ Alpha Lipoic Acid 150mg, 90 caps per bottle _____ bottle(s) @ \$40 / bottle

Acetyl L-Carnitine 500mg, 120 caps per bottle _____ bottle(s) @ \$29 / bottle

LDN 1mg capsules, 1mg, 112 caps per bottle _____ bottle(s) @ \$90 / bottle (lasts at least 4 weeks)

LDN liquid 1mg/ml, 112ml per bottle _____ bottle(s) @ \$133 /bottle (lasts at least 4 weeks)

HonoPure 250mg capsules, 120 caps per bottle _____ bottle(s) @ \$93 / bottle (lasts ~2 - 4 weeks)

Pectasol-C lime powder, 551g bottle _____ bottle(s) @ \$110 / bottle

Vitamin D liquid 1000IU per 0.2ml, 100ml _____ bottle(s) @ \$34 / bottle (lasts ~7 weeks at 10,000U / day)

Other: Name _____ Quantity _____

Delivery Method

pickup from pharmacy in Scarborough pickup from Medicor office

delivery by courier in Toronto area delivery by FedEx

When?

same day next business day this week next week other: _____

Payment Method

same as before other: _____

Patient Name _____

Signature _____ **Date** _____

Medications are not refundable once dispensed. Please ensure you are ordering only what you need.

Prices updated Mar 2016

**Medicor Cancer Centres, 4576 Yonge St. Suite 301, Toronto, ON M2N 6N4
(416) 227-0037 (phone), (416) 227-1915 (fax)**



**Governing Law and Jurisdiction Agreement
(For Non-Canadian Patients Only)**

I hereby agree that:

- a) all aspects of the relationship between me and Medicor Cancer Centres Inc., as well as its agents, delegates, employees, and any physicians and other independent health care practitioners providing medical or other health care and treatment to me, or in association with Medicor Cancer Centres Inc., including without limitation any medical or other health care and treatment provided to me, and
- 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 of Ontario and the laws of Canada applicable therein.

I hereby acknowledge that the medical or other health care and treatment I receive from Medicor Cancer Centres Inc. will be provided in the Province of Ontario, and that the Courts of the Province of Ontario 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 health care and treatment, or from any other aspect of my relationship to Medicor Cancer Centres Inc.

Date

Name of Patient (Please print)

X_____
Signature of Patient or
Substitute decision-maker on behalf of patient