Patient – Family Physician Agreement

Ensuring your health and well-being is our utmost priority. To ensure optimal care, we kindly request your cooperation with the following guidelines. If you have any queries regarding these policies, please feel free to discuss them with us. The following guidelines adhere to the current standards set by the College of Physicians and Surgeons of BC (CPSBC).

Patient Commitment

- Choose your doctor as your primary physician.
- Identify your primary care physician when visiting any healthcare provider or the emergency room.
- Refrain from having another physician or utilizing walk-in clinics as your regular source of care (violation may result in dismissal from the practice).
- Respect your doctor's medical assessment and opinion.
- Treat clinic staff with respect and refrain from any form of verbal or physical aggression (violation may result in immediate dismissal from the practice).

Appointment Scheduling

- Standard appointments are 10-15 minutes, depending on the nature of the visit.
- A discussion limit of 1 medical concern is allocated per appointment. For additional medical issues, please schedule separate appointments. If you have multiple concerns, your doctor may prioritize them during the appointment and schedule follow-up visits for unresolved issues.
- Patients are limited to one appointment per day; the clinic reserves the right to cancel any additional appointments scheduled for the same day.
- Please provide the clinic with the reason(s) for your visit whenever possible to allow for appropriate scheduling.
- Urgent matters, such as acute infections or minor injuries, may qualify for same or next business day appointments. Prescription refill requests do not fall under urgent visits.
- Prescription refills requested by pharmacies without an appointment will not be accepted.
- Appointments can be scheduled online or by contacting the clinic during office hours. Emails are typically not accepted methods of communication for scheduling appointments.

Virtual Appointments

- For virtual visits, your doctor may contact you within +/- 60 minutes of the scheduled appointment time.
- Your doctor will attempt to reach you twice for virtual appointments. Please adjust your phone settings to accommodate calls from unknown numbers or blocked numbers.
- Failure to answer after two attempts will be considered a missed appointment.

Late or Missed Appointments

- Please cancel appointments at least 48 hours in advance.
- Notify the clinic by phone if you anticipate being late for your appointment. While efforts will be made to accommodate you, tardiness may result in a missed appointment, especially if exceeding 15 minutes.
- Missed appointments, no-shows, or late cancellations will incur an out-of-pocket fee.

Office Hours

- Office hours are subject to change. Please refer to our website or contact the office for the most current information.
- For all medical emergencies during and outside of clinic hours, please proceed to the nearest Emergency Department.

Access to Medical Records

- Your medical records are securely stored in compliance with BC's Personal Health Information Act, with your doctor serving as the custodian.
- You may request a copy of your medical records at any time, with applicable fees outlined in Appendix A.
- Implied consent is granted for the sharing of pertinent medical information when requesting specialist referrals.
- Medical information will not be shared with third parties without your explicit written consent.
- Records are retained for 16 years from the date of last entry or from the age of majority whichever is later.

Communication

- Communication with the clinic may occur via phone, email, or secure messages. By consenting, you acknowledge the potential risks and limitations of electronic communication.
- Limited services are available via Email communication. Emails sent to the clinic may not be responded to.

Uninsured Services

- Some services are not covered by the provincial Medical Services Plan (MSP). Service fees will be disclosed before service delivery (refer to Appendix A).
- Common uninsured services include complete physicals for asymptomatic individuals, sick notes, chart transfers, cosmetic procedures, and others.
- Payment for uninsured services is expected upon arrival at the next appointment
- Repeated failure to pay may result in dismissal from the practice.

Recording

- For security purposes, a security camera is installed in the waiting area only.
- Recording encounters without prior consent is discouraged and may lead to immediate dismissal from the practice.

Opioids, Sedatives, and Controlled Substances

- Your doctor adheres to CPSBC policies regarding the prescription of opioids and sedative medications, with safety as a primary concern.
- Long-term prescribing of opioids requires a formal Opioid Treatment Agreement, which may include measures such as random urine drug screening and restriction to a single prescribing physician and pharmacy.
- Breach of the Opioid Treatment Agreement will result in termination of opioid prescribing and possible termination of the therapeutic relationship.

Locum Physicians

- A locum physician is a fully qualified doctor who temporarily fills in for your family physician when they're away or unavailable. Our clinic works with locums to ensure you continue receiving safe, high-quality care without interruption. There are times when you may be seen by a locum rather than your regular attending physician.
- A locum physician is **NOT** your Most Responsible Physician (MRP)/attending family physician.

Medical Students and Residents

- Our clinic is a teaching facility affiliated with the UBC Faculty of Medicine, where we provide educational opportunities for medical students and resident physicians. By agreeing to be a patient at our clinic, you understand that you may be seen by resident physicians who are supervised by experienced attending physicians. These residents are in the advanced stages of their medical training.
- Patient care provided by resident physicians is done with the intent to support their education, and they have access to your medical records for this purpose, ensuring continuity and quality of care.

Language

- Your doctor may only be proficient medicolegally in English only. Please arrange for your interpreter if needed.
- The clinic does not provide translation services. Patients are responsible for arranging their own interpreters or translators. Interpreters and translators must be at least 18 years of age and be readily available at the time of the appointment
- The clinic reserves the right to cancel or reschedule any appointments if the patient is unable to effectively communicate with the doctor due to language which may result in a late cancellation fee.

Termination of Therapeutic Relationship

- The patient-doctor relationship may end due to various reasons
- CPSBC lists examples of situations where ending the patient-registrant relationship are warranted:
    - Patient exhibits threatening or abusive behaviour towards the registrant or their medical office staff, including behaviour or comments of a sexualized or racist nature; as employers, registrants have a legal obligation to make reasonable efforts to ensure that their employees are afforded a harassment-free workplace.
    - Patient poses a risk of harm to the registrant or their medical office staff.
    - Patient makes an unambiguous declaration of non-confidence in the registrant; where a patient's behaviour makes it clear that the practice is not being utilized as a primary care home by (for example) repeatedly attending at other clinics unnecessarily.
    - Patient has repeatedly failed to pay for services after multiple discussions.
    - Patient moves to another community, making required in-person assessments impracticable.
- Your doctor will provide a 90-day advance notice in compliance with CPSBC requirements. After termination, emergency care may be provided for up to 30 days, unless dismissal is due to safety concerns.
- Patients have the right to transfer care at any time, with applicable fees outlined in Appendix A.

By signing below, you acknowledge reviewing and understanding the above policies and agree to adhere to them.

_____ _____

Print name Date Signed (DD/MMM/YYYY)

_____

Signature

Appendix A: BC Family Doctors Fees Guide for services not covered by MSP (2025). College of Physicians and Surgeons of British Columbia Practice Standard: Ending the Patient-registrant Relationship.

Patient Consent Form for Allied Health Access to Medical Records

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Purpose of this Consent Form

Your health care team may include allied health professionals who work in collaboration with your family physician to support your care.

This consent form allows these team members to access your health records held at Westwood Medical Clinic so they can provide safe, informed, and coordinated care.

I, the undersigned, authorize **Westwood Medical Clinic** to share my personal health information, including my electronic medical records, with **authorized allied health professionals** who are a part of my care team. This may include clinical pharmacists, registered nurses, locum physicians or other regulated health professionals under the supervision of my family physician.

Patient Declaration

- I have read and understood this form.
- I understand that I may withdraw my consent at any time by notifying the clinic in writing.
- I understand that refusing or withdrawing consent may affect the services I receive from allied health providers, but not my care from my family physician.

Signature of Patient (or Substitute Decision Maker):

Printed Name of Patient (or SDM):

Date Signed (YYYY-MMM-DD):

Relationship to Patient (if SDM):

Substitute Decision Maker (SDM): someone who makes health care decisions for you **if you're not able to make them yourself**—for example, if you're unconscious, too sick to communicate or you are signing on behalf of a minor.

New Patient - Westwood Medical Clinic

Please complete this form to the best of your abilities and comfort level, as this will help us gain a better understanding of your care needs.

Please note: Our clinic is primarily English speaking. Submission of an application does not guarantee acceptance. Due to the high volume of inquiries, only accepted applicants will be contacted via email or phone.

☐ **First Responder Staff** **Date Form Completed:** _____

Legal First Name:	**Preferred Name (if applicable):**	**Legal Last Name:**
Date of Birth (YYYY-MMM-DD):	**Care Card Number (PHN):**	
Address: *(please include city and postal code)*		**Gender:** Female
Email:		
Primary Contact Phone: ☐ **Cell Phone:** _____ ☐ **Home Phone:** _____		
Occupation:		
If you are unable to speak English fluently, provide a contact who can speak on your behalf *Name:* *Relationship:* *Phone Number:*		**Indicate all languages that you speak fluently (check all that apply):** ☐ **English** ☐ _____ ☐ _____
Emergency Contact: *Name:* *Relationship:* *Phone Number:*		

Please complete and submit this form Westwood Medical at info@westwoodmedicalgroup.com with the subject line "New Patient - Last Name, First Name".

New Patient - Westwood Medical Clinic

Previous Family Doctor & Clinic

Name:

Address/Location:

Preferred Pharmacy

Name:

Address/Location:

Phone Number:

Allergies: *(include the **trigger and reactions** you get, e.g. Peanuts - rashes)*
If none applicable, please write "None" or "N/A"

Please List All Family Members Registered or Planning to Register at Westwood Medical Clinic, if applicable: *(Full legal name - PHN - Relationship to you)*

NOTICE: EACH INDIVIDUAL REGISTERING MUST COMPLETE A FULL INTAKE FORM. NOTING THEIR NAME'S HERE DOES NOT REGISTER THE PATIENT.

Family History - Please list known medical condition(s) under specific family member(s) below.

Biological Father:	*Biological Mother:*	*Siblings:*

Please complete and submit this form Westwood Medical at info@westwoodmedicalgroup.com with the subject line "New Patient - Last Name, First Name".

New Patient - Westwood Medical Clinic

Children:	*Other Family Members (optional):*

Your Current/Previous Medical Conditions: (include year of diagnosis and names of specialists/other health professionals, if known)
If none applicable, please write "None" or "N/A"

Current Medications (*If none applicable, please write "None" or "N/A"*)**:**
Prescription Medications (please include dosage):

Over the counter, Herbal remedies, Supplements:

Your Past Surgeries: *(include the **year of procedure & surgeon,** if known)*
If none applicable, please write "None" or "N/A"

Obstetrical History (*If none applicable, please write "None" or "N/A"*):

How many children do you currently have? _____

At what age did you begin menopause? _____ / Not applicable ☐

Please complete and submit this form Westwood Medical at info@westwoodmedicalgroup.com with the subject line "New Patient - Last Name, First Name".

New Patient - Westwood Medical Clinic

Routine Screening Tests: *(Please include the **most recent month & year, location, and results** if known. If none applicable, please write "None" or "N/A")* Complete physical examination:	
Screening bloodwork:	
Pap Smear:	
Prostate exam:	
Mammogram:	
FIT / Stool test (colon cancer screening):	
Colonoscopy:	
Other recent medical labs/imaging tests:	
Immunizations you have received Pneumonia: ☐ Pneumovax ☐ Prevnar	**Date Received** Pneumovax _____ Prevnar _____
Shingles: ☐ Zostavax ☐ Shingrix	 Zostavax _____ Shingrix _____
Tetanus: ☐ Vaccine/Booster within past 10 years	
☐ Flu Shot	
☐ COVID-19: _____	Number of Doses: _____

Please complete and submit this form Westwood Medical at info@westwoodmedicalgroup.com with the subject line "New Patient - Last Name, First Name".

New Patient - Westwood Medical Clinic

☐ HPV	
☐ Hepatitis A ☐ Hepatitis B	Hepatitis A _____ Hepatitis B _____
Other (please indicate name and # of doses):	

Consent for Email and Voicemail Communication

By signing below, I consent to Westwood Medical Clinic contacting me via email and/or voicemail using the information I provided. I understand this may include appointment reminders, test results, or other medical information. I acknowledge the risks of unauthorized access with these methods and that I can revoke this consent at any time in writing.

Signature: _____ Date Signed: _____

Printed Name: _____

Please complete and submit this form Westwood Medical at info@westwoodmedicalgroup.com with the subject line "New Patient - Last Name, First Name".