Dr. Yasmin Papadopoulos, MD, CCFP
20 Wynford Drive, Suite 302
Don Mills, Ontario M3C 1J4
Tel: 416-445-9673
After hour info line: 416-486-1956

CLINIC POLICIES

Please find the clinic policies listed below to better help you with your medical needs.

Also included is the outside use policy as outlined in the Ministry of Health registration form.

Every effort will be made to accommodate any issues you may have in a timely fashion from 9am-5pm, Monday to Friday by calling our office. Messages will be returned on the same business day by one of our staff members.

Patients who have an urgent medical issue are advised to contact this clinic first for advice. If the physician is not available, an after-hours clinic is available to help you.

Please call the *after-hours info line at 416-486-1956 to book an appointment between Monday to Thursday from 5-8pm and for more information regarding clinic hours on Friday-Sunday.*

This telephone number will be listed on the office voicemail or can be provided by the front desk staff.

Patients who continuously seek medical attention from walk-in clinics or house call physicians will have their enrollment terminated from the practice. Unenrolled patients will not have access to same day appointments, after-hours clinics, telephone advice and fax prescription referrals.

Should you ever have a medical emergency, please go to your nearest emergency department.

Forms and Requests

Please allow *10-15 business days* for completion of all forms, referrals and requests. Requests will be triaged and dealt with in order of urgency.

Health Cards

A valid health card must be presented at each visit. If you forget your health card or it has expired, you will be charged for the cost of the visit. This charge will be reimbursed to you once a valid health card is presented. You must bring your health card to EVERY visit.

Cancellation Policy

Please advise us at least 24 hours in advance should you need to cancel your appointment, otherwise there will be a charge for the missed visit.

Late and Missed Appointments

There will be a fee of $50 for late or missed appointments. If you continually have late or missed appointments you may be discharged from the practice.

Acute Illness and Same-Day Appointments

Every effort will be made to provide same-day appointments for patients that need to be seen urgently. Please call at 9am for same day appointments if you have an urgent medical issue.

Periodic Health Exams (Physicals)

A physical must be booked in advance as this visit will be dedicated to a comprehensive health audit and education session. You should not save problems or urgent issues for this appointment.

Prescription Refills

Please have your pharmacy fax any refill requests to our office *at least 1 week prior* to running out of your medications. (There is a charge for fax renewals if you are not covered under the annual block service fee currently for Dr. Hogarth's patients)

Services not Covered by OHIP/Annual Block Service Fee

A list of non-OHIP insured services can be found at the front desk in addition to the list of services covered under the annual block service fee. The costs of the services listed are as per the recommendations of the Ontario Medical Association.

Physical and Verbal Abuse

Physical and verbal abuse will **NOT** be tolerated towards the physician, staff or patients. Any such behavior will result in immediate dismissal from the practice.

We greatly look forward to working together with you to maintain your good health.

Sincerely,

Dr. Yasmin Papadopoulos, MD, CCFP

HEALTH HISTORY QUESTIONNAIRE

Name: *(Last, First)*	**DOB:** *(yyyy/mm/dd)*
Gender:	**Health Card#:**
Address:	**Cell:** **Home:**
Preferred Pharmacy Address:	**Tel:** **Fax:**
Email Address: *(Please see email policy)*	
Permission to leave voicemail/send email regarding test results, etc: ☐ Yes ☐ No	
Emergency Contact: *Relationship:*	**Tel:**
Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed	
Place of Birth:	**If not Canada, when did you immigrate?**
Education:	**Occupation**:
Referred By: ☐ HCC ☐ Other (Specify)	

PERSONAL HEALTH HISTORY

Immunizations and Dates:	☐ Tetanus:	☐ Chicken Pox:
	☐ Diphtheria:	☐ Hepatitis A:
	☐ Polio:	☐ Hepatitis B:
	☐ Pertussis:	☐ Meningitis:
	☐ Hib:	☐ HPV:
	☐ Pneumonia:	☐ Influenza:
	☐ Rotavirus:	☐ Shingles:
	☐ Meningitis:	☐ Other:
	☐ MMR:	☐ Other:

List any MEDICAL PROBLEMS diagnosed by a doctor:

1)_____
2)_____
3)_____

List any HOSPITALIZATIONS (include year):

1)_____
2)_____
3)_____
4)_____

List any SURGERIES (include year):

1)_____
2)_____
3)_____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Current Medications (prescription and non-prescription *(vitamins, herbal, etc.)***)**

Drug	Dose	Frequency

Allergies to Medications

Drug	Reaction

PREVENTITIVE CARE TESTING

(Note: These tests are recommended for screening after a specific age)

Test	Date	Result
Colonoscopy		
FOBT/Stool Test		
Bone Mineral Density		
Mammogram		
Pap smear		
PSA		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	Do you engage in regular physical activity?		☐ Yes	☐ No
	If yes, what form?	How often?		
Diet	Please outline any dietary restriction:			
Alcohol	If you drink alcohol, what kind?			
	How many drinks per sitting?	Drinks/week?		
Tobacco	Do you use tobacco?	☐ No - Quit Date (DD-MM-YY):	☐ Yes	☐ Never
	Cigarettes: ____ packs/day Pipe: ____/day	Chew: ____/day Cigars: ____/day		
Drugs	Do you currently use recreational drugs?		☐ Yes	☐ No
	If so, which drugs?			
	Have you ever taken drugs with a needle?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children** ☐M ☐F		
Mother			☐M ☐F		
Sibling ☐M ☐F			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			**Other**		
☐M ☐F					

All information is confidential and will become part of your medical record.

Email Policy and Consent Form

Please note that email will be used as a tool to provide patients reminders, resources and electronic documents (i.e. requisitions). Email may be used to schedule appointments in the future.

Email is not to be used in place of an appointment with the doctor. **Urgent matters should not be managed through email and in the event of a medical emergency, patients should go to their nearest emergency department.**

Emails will be checked Monday-Friday from 9 am – 5 pm and will not be checked over the weekend, vacations or statutory holidays. Every effort will be made to respond to emails quickly. Please expect a response time of up to 5 business days. If the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.

Every effort will be made to keep emails confidential, however please note the insecure nature of online communication such as email. It is the responsibility of the patient to prevent unauthorized access to his or her own email system. Please note that the email account will be checked by the office front desk staff and by the doctor.

Email should not be used to discuss sensitive matters. The patient is responsible for informing the office of any types of information the patient does not want to be sent by email. Please be aware that email communication may become part of each patient's medical record.

I agree to indemnify and hold harmless the Physician, her medical practice and employees from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the Internet to communicate with the office, and any breach by me of these restrictions and conditions.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by email. I understand that permission to use online communication may be withdrawn for failure to abide by the terms and conditions of use. Any questions I may have had were answered.

Name _____ Date _____
(Please print)

Signature _____

MEDICAL RECORDS REQUEST DATE:_____ (FAXED)

Attention:_____ Location:_____ Phone: _____ Fax:_____
Patient:_____ Health Card #:_____
Release Request Signed:

Send To:

☐ DR. Y. PAPADOPOULOS

Dr.y.papadopoulos@gmail.com

Fax: 416-445-9388

Suite 302 – 20 Wynford Drive, Toronto, ONTARIO, M3C 1J4, Phone: 416-445-9673

Please either fax, email or send a digital copy (compatible with OSCAR EMR)

Title	Requested
CPP or Chart Summary	
Lab Work	
Radiology	
Consult / Specialist / Hospital Report	
Last FOBT or Colonoscopy (if done)	
Last PAP or Mammogram (if done)	
All immunization and current prescription list	
Other:	

Dr. Yasmin Papadopoulos, MD, CCFP
20 Wynford Drive – Suite 302
Toronto, ON M3C 1J4

Dear Patient,

We are very fortunate in Canada to have access to good healthcare paid for by the Ministry of Health. As our population ages, the cost of healthcare continues to rise and as a result, there are more and more services that are not covered by the Ministry of Health. These services require significant time and resources to deliver. In the face of rising office expenses and government restrictions, we are required to charge for non-OHIP covered services. The payment of these services has become the responsibility of the patient or the agency requesting the services.

There are two ways by which you may address these fees.

The first option is to pay an annual fee, often referred to as a “block fee”, to cover uninsured services for one year. The block fee may be more economical for patients who use uninsured services frequently.

The second option is to pay for individual services at the time the service is provided. Included is a list of items covered by the block fee as well as the fee for individual services.

Please note the fee for fax prescription renewals without an office appointment. If you have not chosen the annual fee, there is a charge for each prescription renewal request, including those sent automatically by the pharmacy. Please speak to your pharmacist if you do not wish to have prescription renewal request automatically sent to our office.

Patients are free to choose the option that best suits them and all patients will have equal access to quality healthcare regardless of the method they choose to pay for non-OHIP covered services. Please see the attached information sheet on block fees provided by the College of Physicians and Surgeons of Ontario.

Please fill out the attached form and return it to our office.

Sincerely,

Dr. Y. Papadopoulos

Dr. Yasmin Papadopoulos, MD, CCFP
20 Wynford Drive – Suite 302
Toronto, ON M3C 1J4

Non-OHIP Covered Services

Patient Name *(last, first)*: _____

Patient Name *(last, first)*: _____
(*if selecting annual fee for couple)*

Family Doctor *(please indicate):* ◯ Dr Y Papadopoulos
◯

☐ **Option A -** I wish to pay the annual fee for uninsured services

Coverage is for each calendar year - January 1st to December 31st

☐ Individual	$120.00 / year
☐ Couple/Two family members	$ 210.00 / year

☐ I have enclosed a cheque made out to my family doctor
☐ I have paid cash in the office

**If you would like to opt into the annual fee after January 1st each year, please ask the front desk for details.*
* *Patients have the right to rescind the decision to pay the annual fee within a week of payment and revert back to paying for individual uninsured services as they are provided*

☐ **Option B -** I wish to pay for individual services when rendered