BLOSSOM N THRIVE
Internal Medicine, Endocrinology and Metabolism Clinic

Dr. Firas Mohammad Riyazuddin, MD DABIM FRCPC
1671 Howard Ave, Windsor, ON N8X 3T6
Ph: 519-256-2323, Fax: 519-253-2626
BlossomNThrive.ca
Billing: 042169, CPSO: 120131

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:

- Maintaining an active family physician where consultation recommendations will be primarily sent.
- 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 uptodate with the clinic. Inccurate 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.

Initial here:

- 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.
- 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.
- Understaning that all private exams for patients regardless of gender MUST be chaperoned by clinic staff.
- 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.
- **Paediatric patients (<=18 y):** 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 Diabetes Wellness Centre 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 Diabetes Wellness Centre, taking steps to stay current with recommended vaccines, eye exams, foot exams and labwork prior to appointments. Special case: Paediatric patients require followup at the Paediatric Diabetes/Metabolic Program, Windsor Regional Hospital. Pregnant patients require followup at the Gestational Diabetes Clinic, Windsor Regional Hospital.
- 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:

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 FIRAS MOHAMMAD RIYAZUDDIN MD, Blossom N Thrive Internal Medicine, Endocrinology & Metabolism Clinic, 1671 Howard Ave, Windsor, ON N8X 3T6
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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.**

Governing Law and Jurisdiction Agreement

for physician in private practice

This agreement ("Agreement") is entered into by and between _____ and
[Name of patient]

FIRAS MOHAMMAD RIYAZUDDIN 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]

FIRAS MOHAMMAD RIYAZUDDIN 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 FIRAS MOHAMMAD RIYAZUDDIN 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 FIRAS MOHAMMAD RIYAZUDDIN 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 FIRAS MOHAMMAD RIYAZUDDIN 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: _____

FIRAS MOHAMMAD RIYAZUDDIN 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 Telephone Consultations	Website at BlossomNThrive.ca for downloadable forms or other general updates from the clinic 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 https://jitsi.org/downloads/	Ontario eConsults Program (https://otn.ca/patients/econsult/)

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_____

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)*

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

Patient signature

Date yyyy-mm-dd

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PATIENT HEALTH INFORMATION SUMMARY & INTAKE FORM

Name (Last name, First name)	
DOB (yyyy-mm-dd)	
Legal gender	[] Male [] Female [] Other
Address	
Emergency contact, relationship and phone number	
Family Doctor	
Other specialists names or members of your healthcare team and city where they are	Physician Name / City ( )
Pharmacy	Name Address 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?	[] Yes [] No
Healthcare proxy	
Allergies	
List your current/past medical diagnoses.	

Diagnosis	Year of Onset	Name of Specialist following if applicable

List past or upcoming surgeries. If known, please mention the approximate year of surgery.	
Active medications. Please also include any over-the-counter medications/remedies/supplements.	

Surgery	Year

Medication name	Dose	Frequency	How often do you forget to take per week?

	<table><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table>
Were you hospitalized in the past year? If so, for what?	
Smoking	[] current: ____ packs per day x ___ years [] former: ____ packs per day x ___ years. Quit in _____
Alcohol	[] current: _____ drinks per week [] former: _____ drinks per week x ____ years. Quit in _____.
Marijuana/Cannabis	[] current: _____ times a week x _____ years [] former: _____ drinks per week x ____ years. Quit in _____.
Illicit drugs.	Which drug: [] current: _____ times a week x _____ years [] former: _____ drinks per week x ____ years. Quit in _____.
Occupation	[] Current occupation: _____ [] Retired, previous occupation: _____ [] Unemployed [] On disability

Are you able to take care of basic activities of daily living? Check all that apply.	[] Bathing, personal hygiene [] Toileting [] Dressing [] Eating [] Moving
Are you able to take care of routine activities of daily living? Check all that apply.	[] paying bills & managing finances [] obtaining or preparing meals [] driving [] shopping [] using a telephone [] commuting [] basic housework & cleaning
Do you live in an assisted living facility?	[] No [] Yes
Are you living in a nursing home?	[] No [] Yes
Do you drive?	[] Yes []No [] Commercial driver
Family History of Medical Problems	Father: Mother: Sibling(s): Children: Paternal Grandfather: Paternal Grandmother: Maternal Grandfather: Maternal Grandmother: Any history of consanguinity in your parents? [] Yes [] No Any history of genetic disorders? [] Yes [] No. If Yes, please describe:

<table>
<tr><td></td><td>If you are diabetic, is there history of diabetes in the family? [] Yes [] No.
If Yes:
1. Any history of diabetes diagnoses <30 years of age? [] Yes [] No. If Yes, pls describe:
2. Any history of Type 1 diabetes? [] Yes [] No. If Yes, pls describe:
3. Any history of a family member requiring insulin within 5 years of diagnosis? [] Yes [] No. If Yes, pls describe:

If you have a history of endocrine tumor (thyroid, parathyroid, adrenal, pituitary, insulinoma, carcinoid, gastrinoma, glucagonoma, VIPoma, testicular, ovarian, etc.); is there a family history of similar endocrine tumors? [] Yes [] No. If Yes, please describe:</td></tr>
<tr><td>Female patients</td><td><table>
<tr><td>Are you pregnant?</td><td>[] No [] Yes</td></tr>
<tr><td>Are you planning a future pregnancy soon?</td><td>[] No [] Yes</td></tr>
<tr><td>Are you breastfeeding?</td><td>[] No [] Yes</td></tr>
</table></td></tr>
<tr><td>Diabetic patients</td><td><table>
<tr><td>When were you diagnosed?</td><td></td></tr>
<tr><td>If you are aware, do you have Type 1 Diabetes?</td><td>[] Yes [] No</td></tr>
</table></td></tr>
</table>

Do you follow with a Certified Diabetes Educator? If yes, list name and approximate date of last visit	[] Yes [] No Name: Approx date:
Do you follow with a Nutritionist? If yes, list name and approximate date of last visit	[] Yes [] No Name: Approx date:
Do you count your carbohydrates?	[] Yes [] No
Do you know your last Hemoglobin A1c?	[] Yes [] No. Last Hemoglobin A1c & approx date:
If you are on insulin, how long have you been on insulin?	
Have you had hospitalizations for Diabetes? List no. of times you were hospitalized for diabetes	[] No [] Yes In past 1 year: In past 3 years: In lifetime:
How often do you check your blood sugar?	[] once a day [] twice a day [] 3-4 times a day [] 6-8 times a day
Do you maintain a blood glucose logbook?	[] Yes [] No
How often do you experience hypoglycemia (blood sugar <4 mmol/L)?	[] never [] almost never [] 1-2 times/month [] 1-2 times a week [] several times a week [] almost daily
Have you had hypoglycemia <3 mmol/L in the past 12 months?	[] Yes [] No
Are you using a Continuous Glucose Monitor (eg. Libre, Dexcom)?	[] No [] Yes If Yes, indicate if you use the manufacturer portal to share and monitor your data: [] Libreview (Libre CGM)

		[] Glooko (Dexcom CGM) [] Other portal:
	Do you wear an insulin pump?	[] No [] Yes Year of first beginning insulin pump therapy: Name of current pump & model: Year obtained: Indicate if you use the manufacturer portal to share and monitor your data: [] Carelink (Medtronic devices) [] Glooko (tslim and Omnipod) [] Other portal: Are you able to navigate the pump menus yourself? [] No [] Yes Are you able to adjust your own pump settings based on the doctor's advice? [] No [] Yes How often do you change the pump settings? ____ per week

		____ per month ____ per year
	Last retina exam	Date (yyyy-mm-dd): Name and contact information of Optometrist/Ophthalmologist:
	Last diabetic foot exam	Date (yyyy-mm-dd): With whom was this performed:
	Approx Date of last flu shot	
	Approx Date of last pneumonia aka Pneumovax-23 or Prevnar-13 vaccine	
	Approx Date of last shingles aka Zoster vaccine	
	Approx Date of last tetanus, diphtheria, pertussis aka Tdap vaccine	
	Approx Date of last Hepatitis B vaccine	
	Approx Date of last HPV vaccine	
	Are you vaccinated for COVID-19?	[] No [] Yes If Yes, list names and approx dates of vaccines [] Pfizer:

		[] Moderna: [] Astrazeneca: [] Johnson & Johnson: [] Other:
	Are you experiencing psychological difficulties due to diabetes?	[] No [] Yes If Yes - Are you following with a mental health team/professional: [] No [] Yes Name and contact of mental health team/professional:

Name of Patient:
DOB:

Guardian/Parent/Power-of-Attorney:

Signature:

Date:

Address: