Forms

How to enroll with
Advancing Care Medical Clinic
Doctors Nadel and Li

Instructions:

To ensure that you receive proper continuity of care and that medical tests, investigations, and reports are available to Doctors Nadel and Li, you'll need to submit a **Patient Enrollment form** and **order a certified copy** of your current medical record(s). You can do this online **OR** by completing these forms.

To complete these forms online go to
www.advancingcare.ca/new-patients
or
follow the instructions below...

1 Complete the **Patient Enrollment** form (**Part 1**).

Complete one form for each adult family member (16 years or older) who wishes to enroll. (Photocopy the form for each additional adult in your household or access additional copies online at the URL above). Each patient has already been assigned to one of the four physicians in Advancing Care Medical Clinic. **On the bottom-right corner of the form, you will see the physician to whom your family has been assigned**. *(Please note that your spot in Advancing Care Medical Clinic is only guaranteed if you enroll by June 1st, 2018 as they will resume enrolling their own patients thereafter.)*

2a Complete the **Authorization to Copy Medical Records** form (**Part 2a**) to order a **certified copy** of your current medical record.

This form authorizes RSRS to prepare and release a copy of your current medical record to your assigned doctor at Advancing Care Medical Clinic. (RSRS was chosen by Doctors Rachlis and Teitelbaum to securely store all their records and to assist their patients with copy and transfer services.)

2b Complete the **Payment for Copy of Medical Records** form (**Part 2b**).

Please note that there is a standardized fee to copy and transfer medical records, which is not covered by OHIP. If you are **not** enrolling with Advancing Care Medical Clinic, you should still use the enclosed form (Part II and Part III) to order a copy of your medical record for another medical practice and/or for yourself.

3 **Once you've completed all the necessary forms, choose one of the following methods to submit them:**

a. **Scan** or take photos of all forms and email to: **advancingcare@rsrs.com**
b. Send the completed forms by **FAX** to: **(416) 398-5932**
c. **Mail** the completed forms using the **enclosed envelope** addressed to **Advancing Care Medical Clinic**
c/o **RSRS**, 111 St. Regis Cres. S., Toronto, ON M3J 1Y6
d. **Bring** the forms to your first appointment with Advancing Care Medical Clinic (the office will also have copies of blank forms, if required)

Ontario

Ministry of Health and Long-Term Care

Part 1

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

One form per adult patient. Photocopy for additional adult family members. To use online form instead, visit www.advancingcare.ca/new-patients.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

☐ or same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

☐ or same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

☐ or same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Section 4 – Family doctor information

(Include Billing no. and Group no.)

Home Telephone No.
( )

Work Telephone No.
( )

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

PHYSICIAN COPY

RSRS

Authorization to Copy Medical Records

Part 2a

One form per family.
To use online form instead, visit www.advancingcare.ca/new-patients

Section A – I want to order my own medical record

Last Name | First Name | Second Name

☐ 16 years of age or older ▼ | Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Signature

X

Section B – I want to order the medical record(s) of other family members

1

Last Name | First Name | Second Name

Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female

☐ 16 years of age or older ▶ | Signature X | Email

2

Last Name | First Name | Second Name

Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female

☐ 16 years of age or older ▶ | Signature X | Email

3

Last Name | First Name | Second Name

Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female

☐ 16 years of age or older ▶ | Signature X | Email

4

Last Name | First Name | Second Name

Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female

☐ 16 years of age or older ▶ | Signature X | Email

Section C – I want my medical records delivered by the following method *(choose only one)*

☐ I want my/our records to go directly to **Advancing Care Medical Clinic**
(No shipping charge)
Skip to Section E

☐ **Secure download** to my computer
(No shipping charge)
Skip to Section E
Email Address: _____
Instructions will be sent by email when the record is ready to download.

☐ Mail **CD** to me
(Complete Section D)
Add $12 shipping and handling.
(1 CD per household) ▼

☐ Mail **Paper** to me
(Complete Section D)
Add $20 shipping and handling
for each record ▼

Section D – I want my/our medical records mailed to the following address *(complete only if you chose the CD or Paper options above)*

Complete mailing address in this section *only* if you chose **CD** or **Paper** in **Section C**.

One destination per order form: all medical records will be sent to only one address or email.

Mailing Address ▶
or
☐ same as Section G

Last Name | First Name

Apt. # | Street

City/Town | Prov. | Postal Code

Continued ➡

RSRS

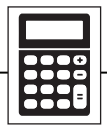
Part 2b

Payment for Copy and Release of Medical Records

One form per family.
To use online form instead visit www.advancingcare.ca/new-patients

Section E – Calculate the fee for copying your medical records. *(Not covered by OHIP)*

Complete this section to calculate the fee to retrieve, assemble, copy and transfer your medical record(s). *Price includes Sales Tax.*



Fee for copying medical records
Print total from calculation on right.

_____ (Copying cost) = _____ Quantity of medical record(s) × $94.50

If you would like more than one copy of the same patient file, contact an RSRS patient services representative at 1.888.563.3732, Ext. 1 or email medicalrecords@rsrs.com.

*For special circumstances (e.g., urgent requests and financial considerations) contact **patient services** at (416) 398-0638, Ext.1*

Comments

☐ **Family discount** Less _____ (Family discount)

If you are ordering for **3 patients** or **more**, deduct $**20**/record

Subtotal
(After deduction) _____ Subtotal

Shipping & handling
(See Section C)
Advancing Care = $**0**
Download = $0
CD = $12
Paper = $20 /patient
_____ (S&H charge, if any)

Total
(Subtotal + S&H) = _____ Total

Section F – Payment method

☐ Credit Card

☐ Visa ☐ MasterCard ☐ Amex ☐ Visa Debit

_____
Credit Card Number

_____ _____
Name on card Expiry date (mm/yyyy)

_____
Cardholder's Signature

☐ Cheque or Money Order
Make cheque payable to: **RSRS, Inc.**

Mail cheque with this form in the enclosed envelope, addressed to:

RSRS,
111 St. Regis Cres. S.,
Toronto, ON
M3J 1Y6

(There is a $25 charge for returned cheques)

Billing Address ▶ ☐ or same as Section G

Apt. # | Street
City/Town | Prov. | Postal Code

Section G – Main contact information and signature

By signing this form each patient / authorized representative, confirms his/her right and authority to receive the information requested. I confirm that RSRS, in releasing this information, is exercising good faith and reasonable action, given its powers and duties in accordance with the Personal Health Information Protection Act (PHIPA 2004, c.3, Sched. A, s. 71 (1)). Signatures on this form are valid for 6 months.

Last Name	First Name	Second Name

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

Apt. # | Street

Email	Date *(yyyy/mm/dd)*	City/Town	Prov.	Postal Code

Home Telephone No.	Work Telephone No.	Signature
( )	( )	X

RSRS – Record Storage & Retrieval Services, Inc. is a fully compliant, physician-managed medical records facility. RSRS provides secure, confidential medical record storage & retrieval services to Canadian doctors. RSRS adheres to strict privacy guidelines and always protects your information.
Please allow 4-6 weeks for delivery once authorization and payment are received. RSRS may contact you if your medical record is oversized.
Personal Information: The patient consents to RSRS's collection, use and disclosure of all personal information disclosed to RSRS in this form, in the application process or in the ongoing administration of this agreement. RSRS will only collect, use or disclose the patient's personal information to identify and contact the patient or to perform any other necessary functions relating to the administration of this agreement or otherwise as required by law. The agreement shall be constructed according to the laws relating to Ontario. CRA #885167544.