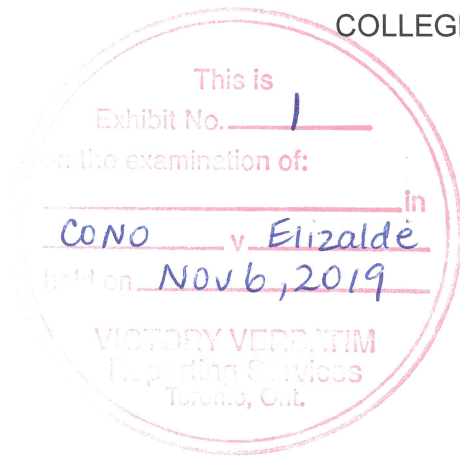


DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF ONTARIO

BETWEEN:

COLLEGE OF NATUROPATHS OF ONTARIO



- and -

SALFE ANNE ELIZALDE

NOTICE OF HEARING

The Inquiries, Complaints and Reports Committee of the College of Naturopaths of Ontario (the "College") has referred specified allegations against you to the Discipline Committee of the College. The allegations were referred in accordance with section 26 of the *Health Professions Procedural Code* which is Schedule II to the *Regulated Health Professions Act, 1991*. The statement of specified allegations is attached to this notice of hearing. A discipline panel will hold a hearing under the authority of sections 38 to 56 of the *Health Professions Procedural Code*, as amended, for the purposes of deciding whether the allegations are true. A **pre-hearing conference** will be held at a date and location to be set by the Presiding Officer. A discipline panel will convene at the offices of the College at 150 John Street, 10th Floor, Toronto, Ontario at **9:30 a.m. on a date to be set by the Registrar**, or as soon thereafter as the panel can be convened, for the purposes of conducting the **discipline hearing**.

IF YOU DO NOT ATTEND ON THE DATE FOR THE HEARING IN ACCORDANCE WITH THE PRECEDING PARAGRAPH, THE DISCIPLINE PANEL MAY PROCEED IN YOUR ABSENCE AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE IN THE PROCEEDINGS.

If the discipline panel finds that you have engaged in professional misconduct, it may make one or more of the following orders:

1. Direct the Registrar to revoke your certificate of registration.
2. Direct the Registrar to suspend your certificate of registration for a specified period of time.
3. Direct the Registrar to impose specified terms, conditions and limitations on your certificate of registration for a specified or indefinite period of time.
4. Require you to appear before the panel to be reprimanded.
5. Require you to pay a fine of not more than \$35,000 to the Minister of Finance.
6. If the act of professional misconduct was the sexual abuse of a patient, require you to reimburse the College for funding provided for that patient under the program required under section 85.7 of the *Health Professions Procedural Code*.
7. If the panel makes an order under paragraph 6, require you to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 6.

The discipline panel may, in an appropriate case, make an order requiring you to pay all or part of the College's costs and expenses pursuant to section 53.1 of the *Health Professions Procedural Code*.

You are entitled to disclosure of the evidence against you in accordance with section 42(1) of the *Health Professions Procedural Code* and Rules 17-20 of the *Rules of Procedure of the Discipline Committee of the College of Naturopaths of Ontario*.

You or your representative may contact Rebecca Durcan, the solicitor for the College in this matter:

Steinecke Maciura LeBlanc
Barristers & Solicitors
401 Bay Street
Suite 2308, P.O. Box 23
Toronto, ON M5H 2Y4

Telephone: (416) 644-4783
Facsimile: (416) 593-7867

Note that, Rules 17-20 of the *Rules of Procedure of the Discipline Committee of the College of Naturopaths of Ontario* also apply to you. Rules 18-20 state as follows:

RULE 18. Documentary Disclosure

- 18.1 Each Party to a Proceeding shall deliver to every other Party (a) a list of, and (b) if not previously produced, copies of, all documents and things that the Party intends to produce or enter as evidence at the Discipline Hearing, in the case of the College, as soon as is reasonably practicable after the Notice of Hearing is served, and in the case of any other party, as soon as is reasonably practicable after disclosure by the College under this Rule, but in any case at least ten (10) days before the commencement of the Pre-Hearing Conference.
- 18.2 A Party who does not disclose a document or thing in compliance with sub-rule 18.1 may not refer to the document or thing or introduce it in evidence at the Discipline Hearing without leave of the Panel, which may be on any conditions that the Panel considers just.
- 18.3 Where a party discovers a document or thing that it will refer to or give in evidence at the hearing after the disclosure date specified in subrule 18.1, the party shall make the disclosure immediately after the discovery.

RULE 19. Fact Witness Disclosure

- 19.1 A Party to a Proceeding shall serve every other Party a list of the witnesses the Party intends to call to testify on the Party's behalf at the Discipline Hearing, in the case of the College, as soon as is reasonably practicable after the Notice of Hearing is served, and in the case of any other Party, at least ten (10) days before the commencement of the Pre-Hearing Conference.
- 19.2 If no affidavit has been served in accordance with Rule 45 (Evidence by Affidavit), and material matters to which a witness is to testify have not otherwise been disclosed, a Party to a Proceeding shall provide to every other Party a summary of the evidence that the witness is expected to give at the

Discipline Hearing on the merits, in the case of the College, as soon as reasonably practicable after the Notice of Hearing is served, and in the case of any other party, as soon as is reasonably practicable after disclosure by the College under this Rule, but in any case at least ten (10) days before the commencement of the Discipline Hearing.

- 19.3 The disclosure obligations set out in Rule 19.2 shall not apply to witnesses called in Reply that the College had no reasonable expectation of calling in-chief.
- 19.4 A witness summary shall contain:
- (a) the substance of the evidence of the witness;
 - (b) reference to any documents to which that witness will refer; and
 - (c) the witness's name and address or, if the witness's address is not provided, the name and address of a person through whom the witness can be contacted.
- 19.5 A Party who does not include a witness in the witness list or provide a summary of the evidence a witness is expected to give in accordance with these rules may not call that person as a witness without leave of the Panel, which may be on any conditions as the Panel considers just.
- 19.6 A witness may not testify to material matters that were not previously disclosed without leave of the Panel, which may be on any conditions that the Panel considers just.

RULE 20. Expert Opinion Disclosure

- 20.1 A Party who intends to call an expert to give expert opinion evidence at a Hearing shall:
- (a) inform the other Parties of the intent to call the expert;
 - (b) identify the expert and the issue(s) on which the expert's opinion will be tendered;
 - (c) serve the other Parties with a copy of the expert's written report or, if there is no written report, an affidavit in accordance with RULE 45 (Evidence by Affidavit), or a witness summary in accordance with sub-rule 19.3; and

- (d) file an "Acknowledgement Form – Expert's Duty" signed by the expert, in the form appended to these rules.
- 20.2 The College shall serve any expert report or affidavit or witness summary upon which the College intends to rely at the Hearing at least sixty (60) days before the commencement of the Hearing.
- 20.3 The Member shall serve any expert report upon which he or she intends to rely at least thirty (30) days before the commencement of the Hearing.
- 20.4 The College may serve a reply expert report at least fifteen (15) days before the commencement of the Hearing.
- 20.5 Where an expert report is filed, it shall at a minimum include the following information:
- (a) qualifications of the expert;
 - (b) the instructions provided to the expert;
 - (c) the nature of the opinion being sought;
 - (d) the factual assumptions upon which the opinion is based; and
 - (e) a list of documents reviewed by the expert.
- 20.6 A Party who fails to comply with sub-rule 20.1 may not call the expert as a witness or file the expert's report or affidavit without leave of the Panel, which may be on any conditions that the Panel considers just.

Date: May 22, 2019



Andrew Parr, CAE
Registrar & CEO
College of Naturopaths of Ontario

TO: **Dr. Salfe Anne Elizalde, ND**
3144 Augusta Dr
Mississauga, ON L5N 5E2

STATEMENT OF SPECIFIED ALLEGATIONS

1. Dr. Salfe Anne Elizalde, ND (the "Member") registered with the College of Naturopaths of Ontario (the "College") on or about November 10, 2015.
2. The Member works at a clinic and at all relevant times was responsible for submitting claims to the insurer electronic system.

Complaint

3. On or about May 17, 2018 the College received a complaint from an insurer alleging that the Member submitted and/or issued false claims. The complaint included the following concerns:
 - a. The Member billed the insurer three separate charges per day for the same patient (i.e. \$120.00 service fee billed as 3 individual \$40.00 service fees, including naturopathic or massage services). This billing pattern was consistent for one particular policy as this policy's coverage allowance only permits a maximum of \$40 per visit for paramedical services;
 - b. After concerns were noted by the insurer, the Member's access to the insurer electronic system was restricted. The Member then began accessing the insurer electronic system and issued claims using an alternate address (her home address as opposed to the clinic address);
 - c. In or around September 2017, Patient A received osteopathy and naturopathy services but the Member only indicated naturopathy services had been provided on the claim issued to the insurer. Osteopathy services are ineligible for reimbursement by this insurer; and/or
 - d. The Member would sign and/or issue a document or documents indicating that she had treated certain patients when the patients had received treatment from someone other than the Member.
4. It is alleged that Member modified her billing pattern to circumvent the insurer's coverage allowance.
5. It is alleged that the Member accessed the insurer electronic system issue using a false or misleading address.
6. It is alleged that the Member's husband treated, or performed some of the osteopathic treatment, on Patient A.

7. It is alleged that the Member did not document her husband's involvement in the osteopathic treatment of Patient A in the patient record and/or the claim issued to the insurer.
8. It is alleged that the Member issued invoices for services she did not provide.

Further Record Keeping Concerns

9. It is alleged that the Member did not maintain an appointment record.
10. It is alleged that the Member failed to maintain financial records in accordance with the standards of the profession.
11. It is alleged that the Member was unable to provide requested patient records to the College investigator upon request.
12. It is alleged that the Member failed to maintain a separate patient record for each patient and/or ensure that patient records can be easily identified or retrieved.
13. It is alleged that the Member failed to maintain patient charts that are accurate, legible and comprehensive.

Allegations of professional misconduct

14. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code") as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:
 - a. **Paragraph 1** (Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession);
 - b. **Paragraph 18** (Issuing an invoice, bill or receipt that the member knows or ought to know is false or misleading);
 - c. **Paragraph 23** (Failing to keep records in accordance with the standards of the profession);
 - d. **Paragraph 24** (Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement); and/or

- e. **Paragraph 46** (Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional).

APPENDIX

1. The documents to be tendered in evidence at the hearing have been sent with this Notice of Hearing.
2. The *Rules of Procedure of the Discipline Committee* have been sent with this Notice of Hearing.
3. Take notice that the documents that have been and may later be disclosed to you will be tendered as business documents pursuant to the *Evidence Act* of Ontario.
4. All documents that are disclosed to you in this matter are disclosed on the basis that they are to be used solely for the purpose of this proceeding and for no other purpose.

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

SALFE ANNE ELIZALDE

DISCIPLINE COMMITTEE
OF THE COLLEGE OF
NATUROPATHS OF ONTARIO

NOTICE OF HEARING

STEINECKE MACIURA LEBLANC
Barristers & Solicitors
401 Bay Street, Suite 2308
P.O. Box 23
Toronto, ON M5H 2Y4

Rebecca Durcan
Telephone: (416) 644-4783
Facsimile: (416) 593-7867
Email: rdurcan@sml-law.com

Lawyers for the College of
Naturopaths of Ontario

**DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF
ONTARIO**

BETWEEN:

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

SALFE ANNE ELIZALDE



AGREED STATEMENT OF FACTS

The parties hereby agree that the following facts may be accepted as true by the Discipline Committee of the College of Naturopaths of Ontario (the "College"):

The Member

1. Dr. Salfe Anne Elizalde, ND (the "Member") registered with the College of Naturopaths of Ontario (the "College") on November 10, 2015. Attached as **Tab "A"** is an excerpt of the Member's profile on the College Public Register.
2. The Member owns or co-owns her clinic and at all relevant times was responsible for submitting claims to the insurer electronic system.
3. This is the first time the Member has been referred to the Discipline Committee. The Member made efforts to resolve this matter soon after the Inquiries, Complaints and Reports Committee referred specified allegations of professional misconduct to the Discipline Committee. The Member is apologetic for, and regrets, her actions.

Complaint

4. On May 17, 2018, the College received a complaint from an insurer alleging that the Member submitted and issued false claims. The complaint included the

following concerns:

- a. The Member billed the insurer three separate \$40.00 charges per day for the same patient (i.e. \$120.00 service fee billed as 3 individual \$40.00 service fees, including naturopathic or massage services). This billing pattern was consistent for one particular policy, as this policy's coverage allowance only permits a maximum of \$40.00 per visit for paramedical services.
- b. After concerns were noted by the insurer, the Member's access to the insurer's electronic system was restricted by the insurer. The Member then began accessing the insurer's electronic system by using an alternate address (her home address as opposed to her clinic address).
- c. In September 2017, Patient A allegedly received osteopathy and naturopathy services from the Member. However, the Member only indicated naturopathy services had been provided on the claim issued to the insurer. Osteopathy services are ineligible for reimbursement by this insurer.
- d. The Member would sign and/or issue a document or documents indicating that she had treated certain patients when the patients had received treatment from someone other than the Member. Attached as **Tab "B"** is a copy of the Complaint Form.

Modifying Billing Pattern

5. It is agreed that the Member modified her billing pattern to circumvent the insurer's coverage allowance of \$40.00 per visit. The Member admits that her usual service fee for naturopathic services was \$120.00 an hour. The Member would break down her billing practice for patients on a certain policy so that they would be charged \$40.00 per service (e.g. naturopathic, massage) as opposed to \$120.00 an hour. The Member admits that she ought to have alerted patients on this specific policy and advised them that their insurance might only pay \$40.00 per visit and that if they wished a full hour of services they would need to pay the \$80.00 differential. The Member admits that she should not have charged the insurer three separate \$40.00 charges for one visit, so that she could collect her regular fee of \$120.00.
6. The Member did reach out to the insurer and sought clarification on the billing practices. However, she now admits that she was unclear as to how the insurer

expected services to be billed.

7. It is agreed that it is a standard of the profession to submit and issue accurate and truthful documents to insurers.
8. It is agreed that it is a standard of the profession to clarify and confirm billing practices before proceeding to do so. As set out in the *Fees and Billing* standard of the College, members are accountable for any fee, billing or account that uses their name. Attached as **Tab "C"** is a copy of the relevant Standard.
9. It is agreed that the above conduct constitutes professional misconduct pursuant to subsection 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:
 - a. **Paragraph 1** (Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession);
 - b. **Paragraph 18** (Issuing an invoice, bill or receipt that the member knows or ought to know is false or misleading);
 - c. **Paragraph 24** (Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement); and
 - d. **Paragraph 46** (Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable or unprofessional).

Accessing the insurer system with a false and misleading address

10. It is agreed that the Member issued claims using her home address and that this was false and misleading. To be clear, the Member never provided services at her home address. All services were provided at the clinic. However, the Member was insistent on collecting her fees so she used her home address as the address where services were provided when billing the insurer with the specific intent of circumventing the restriction imposed by the insurer.

11. It is agreed that it is a standard of the profession to submit and issue accurate and truthful documents to insurers.
12. It is agreed that the above conduct constitutes professional misconduct pursuant to subsection 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:
 - a. **Paragraph 1** (Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession);
 - b. **Paragraph 18** (Issuing an invoice, bill or receipt that the member knows or ought to know is false or misleading);
 - c. **Paragraph 24** (Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement); and
 - d. **Paragraph 46** (Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable or unprofessional).

Alleging naturopathy services had been provided instead of osteopathy services by the Member

13. It is agreed that Patient A received osteopathy services – as opposed to naturopathy services - but not from the Member. The Member's spouse treated and performed the osteopathic treatment on Patient A. A copy of Patient A's audit response to the insurer is attached at **Tab "D"**.
14. It is agreed that having the Member's spouse provide the treatment could only occur if there were an assignment of care or a referral, both of which would require documentation in the patient record.
15. It is agreed that the involvement of the Member's spouse was not indicated in the patient record of Patient A or on the claim issued to the insurer. Attached as **Tab "E"** is a copy of these documents. This is in contravention of the following standards of practice of the profession set out in the College's published

standards and the Assignment of Care Guideline:

- a. A member must ensure that all records contain relevant referral and consultation information and an indication of who made each entry (*Record Keeping Standard of Practice* of the College). Attached as **Tab "F"** is a copy of the relevant Standard.
 - b. It is expected that assignment will only occur with certain processes in place, including documentation/references for performance of procedures (*Assignment of Care Guideline*). Attached as **Tab "G"** is a copy of the relevant guideline.
16. It is agreed that the Member issued invoices for services that she herself did not provide but rather her spouse provided.
17. The Member believed that she could refer or assign this service to her spouse, still have it considered a naturopathic service and bill it as such. The Member agrees that she was wrong to do so. The Member now realizes that if any service is referred or assigned to another provider, the patient must consent, the referral must be recorded in accordance with College requirements, and the invoice must indicate that another service provider provided the service. This is confirmed in the Referral and Consultation Guideline of the College and the Fees and Billing Standard of the College:
 - a. Prior to requesting a consultation or referral, a naturopath must discuss the purpose with the patient and that the patient agrees to the release of information and the choice of health professional (*Referrals and Consultations Guidelines*). Attached as **Tab "H"** is a copy of the relevant Standard.
 - b. Receipts are clearly itemized. (*Fees and Billing Standard*). Attached as **Tab "C"** is a copy of the relevant Standard.
18. The Member recognizes that osteopathy was ineligible for reimbursement from this insurer and that billing the service as naturopathic was misleading and false. The claim to the insurer indicated that she provided this service. She did not.
19. It is agreed that the above conduct constitutes professional misconduct pursuant to subsection 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, as set out in

one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

- a. **Paragraph 1** (Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession);
- b. **Paragraph 18** (Issuing an invoice, bill or receipt that the member knows or ought to know is false or misleading);
- c. **Paragraph 23** (Failing to keep records in accordance with the standards of the profession);
- d. **Paragraph 24** (Signing or issuing, in his or her professional capacity, a document that the member knows or ought to know contains a false or misleading statement); and
- e. **Paragraph 46** (Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable or unprofessional)

Further Record Keeping Concerns

- 20. It is agreed that the Member failed to maintain appointment records, financial records and patient charts in accordance with the following standards of practice of the profession set out in the College's published standards:
 - a. A member must ensure that appointment records, financial records and patient charts are accurate legible and comprehensive (*Record Keeping Standard of Practice* of the College). Attached as **Tab "F"** is a copy of the relevant Standard.
- 21. It is agreed that the Member was unable to provide requested patient records to the College investigator upon request.
- 22. It is agreed that the Member failed to maintain a separate patient record for each patient and ensure that patient records can be easily identified or retrieved.
- 23. It is agreed that the above conduct constitutes professional misconduct pursuant to subsection 51(1)(c) of the *Health Professions Procedural Code*,

being Schedule 2 to the *Regulated Health Professions Act, 1991*, as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

- a. **Paragraph 1** (Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession);
 - b. **Paragraph 23** (Failing to keep records in accordance with the standards of the profession); and
 - c. **Paragraph 46** (Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable or unprofessional).
24. By this document, the Member admits to the truth of the facts referred to in paragraphs 1 to 22 above (the "Agreed Facts").
25. By this document, the Member states that:
- a. She understands fully the nature of the allegations made against her;
 - b. She has no questions with respect to the allegations against her;
 - c. She admits to the truth of the facts contained in this Agreed Statement of Facts and Admission of Professional Misconduct and that the admitted facts constitute professional misconduct;
 - d. She understands that by signing this document she is consenting to the evidence as set out in the Agreed Statement of Facts and Admission of Professional Misconduct being presented to the Discipline Committee;
 - e. She understands that by admitting the allegations, she is waiving her right to require the College to prove the allegations against her at a contested hearing;
 - f. She understands that the decision of the Committee and a summary of its reasons, including reference to her name, will be published in the College's annual report and any other publication or website of the College;
 - g. She understands that any agreement between her and the College

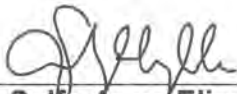
with respect to the penalty proposed does not bind the Discipline Committee; and

- h. She understands and acknowledges that she is executing this document voluntarily, unequivocally, free of duress, free of bribe, and that she has been advised of her right to seek legal advice.

26. In light of the Agreed Facts and Admission of Professional Misconduct, the College and the Member submit that the Discipline Committee should find that the Member has committed professional misconduct.

All of which is respectfully submitted.

Signed this 30th day of October, 2019



Dr. Salfe Anne Elizalde, ND
Member

Signed this 31st day of October, 2019



Andrew Parr, CAE
Registrar & CEO
College of Naturopaths of Ontario



The College of Naturopaths of Ontario

[FRANÇAIS](#) [CART](#)

Public Register of Ontario Naturopaths

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Member Details

Dr. Salfe
 Name: Anne
 Elizalde, ND
 Nickname or Abbreviation: None
 Date Of Registration: Nov 10,
 2015
 Registration #: 3081
 Current Status: In Good
 Standing
 Class of Registration: General
 Class
 Previous First Name: None
 Previous Last Name: None



Registration History

Registrant Class	Status	Effective Date	Notes
General Class	In Good Standing	Nov 10, 2015	Date of initial registration

Extended Services

Additional Standards of Practice	Qualified	Effective Date	Notes
Therapeutic Prescribing is a post-registration Standard of Practice. NDs who wish to prescribe, dispense, compound, sell, or administer by	No		

injection or inhalation the restricted substances available to Ontario NDs under the College's General Regulation must first meet this Standard of Practice. NDs who do not wish to access these substances or perform these controlled acts are not required to meet this Standard.

Additional Standards of Practice	Qualified	Effective Date	Notes
The Standard of Practice for Intravenous Infusion Therapy (IVIT) is a post-registration Standard of Practice. NDs who wish to administer substances intravenously for therapeutic benefit, must first meet this Standard of Practice and the Standard of Practice for Therapeutic Prescribing. NDs who do not wish to administer substances intravenously are not required to meet this Standard.	No		

Terms, Conditions And Limitations

Effective Date	Expiry Date	Type Of Conditions	Notes
No Data Found			

Employment Information

Professional Corporation

Inquiries, Complaints, And Reports Committee Referrals

Inquiries Complaints And Reports Committee - Outcomes

Findings

Member Reported And Other Findings

Registrar's Notation

Public

Overview

The College and You

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IVIT Premises Register

Unauthorized Practitioners

Preventing Sexual Abuse

About Naturopaths

Find a Naturopath

Complaints & Reports

Preventing Sexual Abuse

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CONTACT US

150 John Street, 10th Floor
Toronto, Ontario, M5V 3E3

10/23/2019

Va Public member display

Tel. 416.583.6010

Fax. 416.583.6011



The College of Naturopaths of Ontario

Complaint Form

To initiate a complaint, please follow these steps:

1. Review the Complaints Process on the College's website
[CONO Complaints Process](#)
2. Print and complete or electronically complete the complaint form, and attach documentation and details of complaint as required.
3. Attach any supporting evidence
4. Submit completed complaint form to the College:

By email: complaint@collegeofnaturopaths.on.ca

By Mail: College of Naturopaths of Ontario
Complaints Department
150 John Street, 10th Floor
Toronto, ON
M5V 3E3

By Fax: 416-583-6011

In accordance with the complaints process, the College will send a written notice of the complaint to the Member, together with a copy of this complaint form, so that the member can provide a response.

Page 5 of the form, containing the Complainant's personal contact information WILL NOT BE DISCLOSED to the Member.



The College of Naturopaths of Ontario

Complainant Information

Last Name: [REDACTED] First Name [REDACTED]

Relationship to Member: ☐ Patient ☐ Colleague ☐ Employer

Other [REDACTED]

Patient Information (if different from the person filing the complaint)

Last Name: _____ First Name _____

If you are not the patient, please describe your relationship to that individual (parent, spouse, child, relative, etc.):

[REDACTED]

Please be advised that if you are filing a complaint on behalf of another individual, the College may require the individual to provide consent to access personal information relating to the complaint. A consent form will be provided with the acknowledgement letter.

Naturopathic Doctor Information

(Please provide as much information as possible)

Name: Salfe Anne Elizalde

Company Name: [REDACTED]

Practice Address: [REDACTED]
Street Number Street

[REDACTED]
City Province Postal Code

Registration Number: 3081



The College of Naturopaths of Ontario

Complaint Information

Details of the Complaint

Include date(s) and location(s) of the incident(s) if applicable. Please provide as much detail as possible.

[Redacted content]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

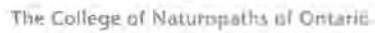
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



If Yes, what was the outcome?

1. _____
2. _____
3. _____

1. _____
2. _____
3. _____
4. _____

Name _____

Date _____

4 | Page



The College of Naturopaths of Ontario

Complainant Information

Last Name: [REDACTED] First Name [REDACTED]

Mailing Address: [REDACTED]
Street Number Street

[REDACTED] [REDACTED]
City Province Postal Code

Telephone Number: [REDACTED]

Email Address: [REDACTED]

☒ I authorize the College to communicate with me via email

Patient Information *(if different from the person filing the complaint)*

Last Name: _____ First Name _____

Mailing Address: _____
Street Number Street

City Province Postal Code

Telephone Number: _____

Email Address: _____

Please be advised that if you are filing a complaint on behalf of another individual, the College may require the individual to provide consent to access personal information relating to the complaint. A consent form will be provided with the acknowledgement letter.



The College of Naturopaths of Ontario

Standard of Practice:

Fees and Billing

Introduction

The intent of this standard is to advise Members with respect to fees and billing for naturopathic services, drugs, substances, products or devices.

Definitions

Block Fee: A flat fee charged for a predetermined set of services or unlimited services.

Markup: the amount added to the cost price of goods to cover overhead costs.

1. Fees and Billing

The Member establishes and maintains fair and ethical fees and billing practices. Members are accountable for any fee, billing or account that uses their name and/or registration number. Naturopaths must be aware of how their names and registration numbers are being used.

Performance Indicators

The Member:

- ensures that patients are informed of the fees to be charged;
- ensures that a fee schedule is established and posted that outlines:
 - the fees for all visits or services;
 - any administrative fees; and
 - penalties for missed or cancelled appointments.
- ensures that the fees charged:
 - are not excessive in relation to the services proposed;
 - for drugs, substances, products and devices are only marked-up to cover the direct overhead expenses incurred in obtaining, storing, dispensing and selling these items;
 - are an accurate reflection of the services provided to each patient.
- May charge a reasonable fee for collecting non-blood specimens to be sent for laboratory testing, and itemize it on the invoice as "collection of specimen"
- May charge the patient for the cost of the test and any associated fee(s) (e.g. requisition/collection fees from the medical laboratory) incurred by the Member.
- Does not charge a mark-up on the cost of the test and any associated fee(s) (e.g. requisition/collection fees from the medical laboratory) incurred by the naturopathic doctor.
- May charge a reasonable fee for the analysis of laboratory test results if it is done outside of a patient visit/consultation

- ensures that any departure from an established or documented fee is consented to by the patient and documented in the patient record;
- Prior to providing care, ensures that the patient is given clear information about fees and that they understand this information, this includes:
 - any relevant financial policies and payment expectations;
 - information on fees and the fee schedule specific to the patient circumstances, including all fees that might apply to the patient;
 - the basis upon which a bill for services is calculated; and
 - the acceptable methods of payment.
- audits invoices and billing practices at periodic intervals to ensure:
 - the accuracy of invoices;
 - an understanding of the fees that are being charged for their services;
 - an understanding of how their registration or billing number is being used; and
 - when abnormalities are discovered, reasonable steps are taken to remedy the situation.
- ensures that processes exist for the timely:
 - notification of any balance due or owing; and
 - provision of applicable refunds.
- does not charge a block fee;
- does not charge a dispensing fee;
- does not offer or give a reduction in fees for prompt payment of services.

2. Receipts

The Member issues a receipt for all payments.

Performance Indicators

Receipts clearly and legibly record:

- name of treating Member, clinic name, address, telephone number;
- Member's registration number;
- patient's name and address;
- date of service;
- services billed;
- fees for supplements, injectable substances, drugs, laboratory tests, devices, special testing, etc.;
- payments received;
- balance owing;
- HST registration number, if applicable.

If a replacement receipt is issued it is clearly marked "COPY".

Receipts are clearly itemized. Fees for naturopathic consultation are separated from all other fees. Fees for supplements, injectable substances, drugs, laboratory tests, devices, special testing, etc., are individually listed, either on the same or another receipt.

The purchase and redemption of vouchers or gift certificates are clearly documented.

Related Standards

Conflict of Interest
Consent
Dispensing
Prescribing
Recommending Non-Scheduled Substances
Record Keeping
Selling

Legislative Framework

Professional Misconduct Regulation

Approval

Original Approval Date: October 15, 2012

Latest Amendment Date: March 6, 2019

Disclaimer

In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.

May 2, 2018

Private & Confidential

RE: Contract #:
Certificate #:
Member:
Patient:

Dear

The claims that appear in the table below have been submitted on your (and/or your dependants) behalf by the service provider shown and have been selected for verification by you.

We would appreciate your cooperation in independently completing all sections that are currently blank in the table below. In order to avoid any delays in future claim approvals, please complete and return this questionnaire within 30 days.

Provider Name	Patient Last Name	Service Billed	Service Date	Total Charged	Rendered Yes/No	Please confirm if additional treatment was received during appointment (Massage or Osteopath)
Salfe Anne Elizalde		Naturopath	01-Sept-2017	\$60.00	yes	Osteopathic Massage
Salfe Anne Elizalde		Naturopath	25-Sept-2017	\$80.00	yes	Osteopathic Massage

If you have any reason to question the accuracy or validity of the claim submitted, or the service you have received at this service location, please note any discrepancies below.

The charges are correct. My osteopathic massage was performed by a male

Thank you for your assistance.

Kind Regards,

[Redacted]
[Redacted]
[Redacted]

I certify that the information in this form is true and complete to the best of my knowledge. I authorize [Redacted] any health care provider, other insurance company, workplace safety and insurance board, my employer, or other persons to release and exchange information for the administration, adjudication, and investigation of these claims. This may include the release of my (and my dependants') confidential claims information to health care regulatory bodies, colleges, boards, and similar organizations, or as a matter of law.

I agree that a copy of this authorization shall be as valid as the original.

I confirm that the services listed above were received by me/patient on the date indicated. I also confirm that the services shown have been submitted to my policy on my behalf.

[Redacted]
Signature

May 7, 2018
Date

[Redacted]
Phone Number

[Redacted]

Note: this communication is intended only for the recipient named above. It may contain information that is privileged, confidential and subject to copyright. Any unauthorized use, copying, review or disclosure is prohibited. Please notify the sender immediately if you have received this communication in error (by calling collect, if necessary) so that we can arrange for its return at our expense.

[Redacted]

Client Intake Form – Therapeutic Massage

Personal Information:

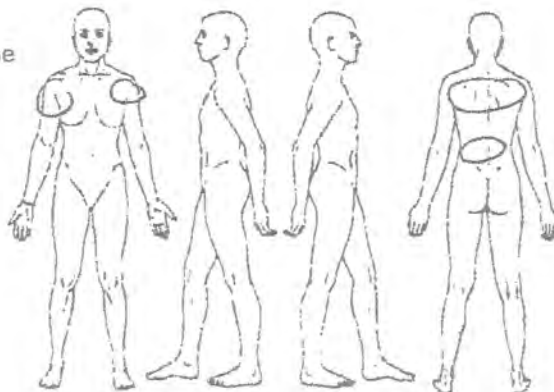
Name [REDACTED] Phone (Day) [REDACTED] Phone (Eve) [REDACTED]
Address [REDACTED]
City/State/Zip [REDACTED]
email [REDACTED] Date of Birth [REDACTED] Occupation [REDACTED]
Emergency Contact [REDACTED] Phone [REDACTED]

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit SEPT 1, 2017

1. Have you had a professional massage before? ☒ Yes ☐ No
If yes, how often do you receive massage therapy? 1 / year
2. Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☒
If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? Yes ☐ No ☒
If yes, please explain _____
4. Do you have sensitive skin? Yes ☐ No ☒
5. Are you wearing contact lenses () dentures () a hearing aid () ☒
6. Do you sit for long hours at a workstation, computer, or driving? ☒ Yes ☐ No
If yes, please describe [REDACTED]
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☒
If yes, please describe _____
8. Do you experience stress in your work, family, or other aspect of your life? Yes ☐ No ☒
If yes, how do you think it has affected your health?
muscle tension () anxiety () insomnia () irritability () other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain
or other discomfort? ☒ Yes ☐ No
If yes, please identify Back
10. Do you have any particular goals in mind for this massage session? Yes ☐ No ☒
If yes, please explain _____

Circle any specific areas you would like the
massage therapist to concentrate on
during the session:



Continued on page 2

Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes ☒ No ☒

If yes, please explain _____

12. Do you see a chiropractor? Yes ☒ No ☒ If yes, how often? _____

13. Are you currently taking any medication? Yes ☒ No ☒

If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session - only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____

Date

SEPT 1, 2017.

Signature of Massage Therapist _____

Date _____

PATIENT CONSENT FORM

PRINT IN CAPITAL ONLY

First name: [REDACTED]
Last Name: [REDACTED]
Gender: [REDACTED] Date of Birth: (mm/dd/yyyy): [REDACTED] Age: [REDACTED]
Phone numbers: (H) [REDACTED] (M) [REDACTED]
Address: [REDACTED]
City: [REDACTED] Postal: [REDACTED]
E mail: [REDACTED]

I hereby request and consent to the service of Naturopathic, Physiotherapy Physiotherapy-assisted therapy, Acupuncture, Osteopath and Massage treatment and other procedures, including various modes of remedial exercise. I understand that I will have an opportunity to discuss with the therapists and or with other office or clinic personnel, the nature of therapy treatment and other procedures. I understand the results may not be guaranteed. I am informed that, as in all health care, in the practice of therapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, bruising, light headed or dizziness, and tenderness. I do not expect the therapist to be able to anticipate and explain all risks and complications and I wish to rely on the therapist to exercise judgment during the course of the treatment which the therapist feels at the time, based upon the facts then known, and is in my best interests. I understand that I will be draped at all times and the areas undraped will be secure to insure there is no indecent exposure. If undraping my gluteal is significant in the treatment, I do understand that it is part of the therapy. I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the treatment. I am aware there are further alternatives offered such as Naturopathic, Acupuncture, Massage, Osteopath and Physiotherapy etc. I have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

Cancellation Policy Before 48 hours - No Charge; Within 48 hours - 50 % charge; Within 24 hours 75 % charge Dated this _____ day of _____ 20____

Signature: [REDACTED]

Legal Guardian: _____

Or

Witness Signature: _____

Dr. Salfe Anne Elizalde, ND
Naturopathic Doctor

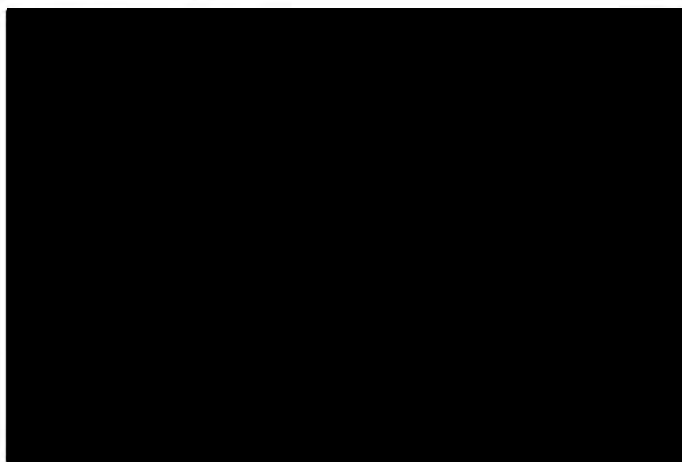
Nilesh Thakor
Registered Physiotherapist

Ranilo Casas
Resident Physiotherapist

Eriksson Kerr
Registered Manual Osteopath

Zarish Gill/Jesus Aspill
Registered Massage Therapists

Shiela Casas
PT Assistant/ND Assistant



TREATMENT NOTES

PATIENT NAME: [REDACTED]

S: Chief Complaints	Pt came in for the complaints of tightness of the upper back, and shoulder both sides. Noted mostly every after work working as a bus driver. No injury occurred, no imaging done, not seen other provider, no other medical concern, no tingling or numbness of the extremities.
O: Objective Findings Orientation: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time V/S: Stable	(+) tight levator scapula Bilateral (+) tender coracoid process B (+) tight SITS muscle Bilateral
A: Clinical Findings/Prognosis	Cervicalgia, Rotator cuff muscle Strain Bilateral
P: Plan (Informed Consent Obtained <input checked="" type="checkbox"/>) <input checked="" type="checkbox"/> Treatment <input checked="" type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herbs <input checked="" type="checkbox"/> Therapy	1. Assessment 2. Myofascial Release Therapy <div style="text-align: right;">Duration 40mins</div>
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date: Sept 1, 2017

S: Chief Complaints	follow up treatment following the last visit. No change of symptoms. No worsening of symptoms. Tolerated treatment last visit.
O: Objective Findings Orientation: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time V/S: Stable	(+) tight levator scapula Bilateral (+) tender coracoid process B (+) tight SITS muscle Bilateral
A: Clinical Findings/Prognosis	Cervicalgia, Rotator cuff muscle Strain Bilateral
P: Plan (Informed Consent Obtained <input type="checkbox"/>) <input type="checkbox"/> Treatment <input type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herb <input type="checkbox"/> Therapy	1. Myofascial Release Therapy 2. Joint mobilization <div style="text-align: right;">Duration: 30 mins</div>
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date: Sept 25, 2017

S: Chief Complaints	
O: Objective Findings Orientation: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time V/S:	
A: Clinical Findings/Prognosis	
P: Plan (Informed Consent Obtained <input type="checkbox"/>) <input type="checkbox"/> Treatment <input type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herb <input type="checkbox"/> Therapy	
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date:

TREATMENT NOTES

PATIENT NAME: _____

S: Chief Complaints	
O: Objective Findings Orientation: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time V/S:	
A: Clinical Findings/Prognosis	
P: Plan (Informed Consent Obtained <input type="checkbox"/>) <input type="checkbox"/> Treatment <input type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herbs <input type="checkbox"/> Therapy	
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date:

S: Chief Complaints	
O: Objective Findings Orientation: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time V/S:	
A: Clinical Findings/Prognosis	
P: Plan (Informed Consent Obtained <input type="checkbox"/>) <input type="checkbox"/> Treatment <input type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herb <input type="checkbox"/> Therapy	
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date:

S: Chief Complaints	
O: Objective Findings Orientation: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time V/S:	
A: Clinical Findings/Prognosis	
P: Plan (Informed Consent Obtained <input type="checkbox"/>) <input type="checkbox"/> Treatment <input type="checkbox"/> Assessment <input type="checkbox"/> Acupuncture <input type="checkbox"/> Supplement/Herb <input type="checkbox"/> Therapy	
Practitioner's/Therapist's Name	Dr. Salfe Anne Elizalde, ND Date:

Claims
enabled



powered by

TELUS HEALTH

Explanation of Benefits

Expected Payment Date: Unavailable

Total Payable To: Clinic/Organization
Payee Name: Elizalde Integrative Health

Insurance Co. Claim ID: [REDACTED]
Policy: [REDACTED] (Extended Health Care)
Insured Member: [REDACTED]
Member ID: [REDACTED]
Date of Birth: [REDACTED]

Servicing Provider: Sallie Anne
Elizalde

Servicing Location ID: 255951
Licence ID: 3081

Patient: [REDACTED]
Relationship: Insured Member
Dependent ID: -
Date of Birth: [REDACTED]

Claim accepted

Claim has been accepted and payment will be made to Clinic/Organization.

Please see Insurer notes for a detailed explanation of benefits.

Provider Claim Reference ID: [REDACTED]
Date Submitted: 2017-09-05

Date of Service	Service Description	Submitted	Eligible	Deductible	Payable at	Paid amount	Note(s)
2017-09-01	Naturopathy	\$40.00	\$40.00		100%	\$40.00	
2017-09-01	Massage	\$40.00	\$40.00		100%	\$40.00	
	Totals:	\$80.00				\$80.00	

Insurer's note(s)

[REDACTED]

Claims
enabled



powered by

TELUS HEALTH®

Explanation of Benefits

Expected Payment Date: Unavailable

Total Payable To: Clinic/Organization

Payee Name: Elizalde Integrative Health

Insurance Co. Claim ID

Policy (Extended Health Care)

Insured Member:

Member ID

Date of Birth:

Servicing Provider: Salfe Anne
Elizalde

Servicing Location ID: 255951

Licence ID: 3081

Patient:

Relationship: Insured Member

Dependent ID: -

Date of Birth:

Claim accepted

Claim has been accepted and payment will be made to Clinic/Organization.

Please see Insurer notes for a detailed explanation of benefits.

Provider Claim Reference ID:

Date Submitted: 2017-09-26

Date of Service	Service Description	Submitted	Eligible	Deductible	Payable at	Paid amount	Note(s)
2017-09-25	Massage	\$40.00	\$40.00		100%	\$40.00	
2017-09-25	Massage	\$20.00	\$20.00		100%	\$20.00	
	Totals:	\$60.00				\$60.00	

Insurer's note(s)



The College of Naturopaths of Ontario

Standard of Practice:

Record Keeping

Introduction

The intent of this standard is to advise Members with respect to the expectations for record keeping in their practice. This standard applies to both written and electronic records as appropriate.

Definitions

Patient Record: Consists of the patient chart, appointment record and financial records.

1. Appointment Records

The Member maintains an appointment record that is accurate, legible and comprehensive.

Performance Indicators

The Member maintains an appointment record that clearly and legibly identifies:

- Member's name, clinic name, address and telephone number;
- date and time of appointment;
- name of patient (minimum of last name and first initial); and
- duration of appointment.

The Member maintains and retains appointment records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

2. Patient Financial Records

The Member maintains a financial record that is accurate, legible and comprehensive.

Performance Indicators

The Member ensures that financial records clearly and legibly record:

- name of treating Member, clinic name, address, telephone number;
- patient's name, address and telephone number;
- date of service;
- services billed;
- substances, drugs or devices dispensed;
- payment amount and method of payment; and

- balance of account.

The Member ensures that:

- patient financial records are clearly itemized;
- fees for naturopathic consultation are separated from all other fees;
- fees for supplements, injectable substances, devices, special testing, etc., are individually listed;
- receipts are issued for all payments and copies are maintained in the patient financial record.

The Member maintains and retains financial records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

3. Patient Charts

The Member maintains a patient chart that is accurate, legible and comprehensive.

Performance Indicators

In all patient charts, the Member ensures:

- all written entries are made in indelible ink;
- the patient's name or patient number is recorded on each page;
- all entries are made in either English or French. Other languages may be used provided that English or French are also used;
- there is no highlighter used over writing;
- all written records are clearly legible;
- there are no blank spaces between entries;
- all pages are in chronological order, consecutively numbered and dated;
- a consistent format is used for recording the date;
- all chart entries are recorded as soon as possible after the patient interaction; and
- when other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.

The Member ensures that all records contain:

- the patient's chief complaint(s);
- relevant health, family and social history;
- subjective information provided by the patient or their authorized representative;
- relevant objective findings;
- consent;
- results of any naturopathic examinations;
- an assessment of the information and any diagnosis;
- proposed treatment plan, including prescriptions and recommendations;
- relevant communications with or about the patient;
- the patient's reactions/feedback to treatment
- relevant information obtained from re-assessment;
- relevant referral and consultation information, where applicable; and
- indication of who made each entry and when the entry was made.

The Member records the following information related to the delivery of treatment:

- name and strength of all drugs and/or substances administered;
- dosage and frequency;
- date of administration;
- method of administration; and
- how treatment was tolerated.

The attending Member includes his/her registration number and signs the written record so that the treating ND is clearly identified.

The Member maintains and retains patient records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

4. Electronic Records

The Member ensures that electronic records are maintained and retained in a safe and effective manner.

Performance Indicators

Electronic records are subject to the same security requirements as paper/written information. The Member ensures that, when patient records are maintained in an electronic system, the following criteria are met:

- the system provides a visual display of the recorded information;
- the system provides a means of accessing the record of each patient by the patient's name or other unique identifier;
- the system is capable of printing the recorded information in chronological order for each patient;
- the system maintains an audit trail that:
 - records the date and time of each entry for each patient;
 - preserves the original content of the record if changed or updated;
 - identifies the person making each entry or amendment; and
 - is capable of printing each patient record separately.
- the system provides reasonable protection against unauthorized or inappropriate access;
- the system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records;
- backed-up files are stored in a physically separate and secure area; and
- files are encrypted if they are transferred or transported outside of the facility.

When making the transition from paper to electronic records, the Member must:

- ensure the integrity of the data that has been converted into electronic form;
- verify that documents have been properly scanned;
- ensure that the entire patient record is intact upon conversion, including all attached notes and hand-written comments.

5. Storage of Charts

When storing patient charts, the Member takes reasonable measures to ensure patient confidentiality and security of patient information to prevent unauthorized access and maintain its integrity.

Performance Indicators

The Member:

- ensures all patient charts are secured;
- ensures sensitive information is never left unattended in an unsecured location;
- stores all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved;
- maintains a separate chart for each patient; and
- ensures, if other practitioners also see the same patient, that the Member's electronic records can be individually retrieved.

6. Amendments to Patient Charts

The Member ensures that any amendments made to a patient chart are properly documented.

Performance Indicators

The Member ensures that:

- any amendment to a written chart is initialed, dated and indicates what change was made;
- all previous written entries remain legible;
- amendments are only to be in the form of additions and not erasure or overwriting;
- the original entry is available and legible;
- a patient chart is never re-written.

7. Privacy

The Member adheres to the Personal Health Information Protection Act, 2004 (PHIPA).

Performance Indicators

The Member obtains the patient's consent when collecting, using or disclosing personal health information unless provided otherwise by law.

The Member maintains patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information.

The Member identifies the Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information. The patient is informed of who has custody and control of their personal health information and how their information will be managed.

All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access.

8. Retention and Transfer of Patient Records

When retaining and transferring records, the Member takes reasonable measures to ensure confidentiality and security of information to prevent unauthorized access and maintain the record's integrity.

Performance Indicators

The Member:

- maintains the original chart unless it is requested by the College for a regulatory purpose or is required for legal purposes in which case a copy is retained by the Member;
- never provides any information concerning a patient to a person other than the patient or their authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise required by law;
- may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Member shall not require prepayment of this fee. Non-payment of the fee is not a reason for the Member to withhold the information;
- retains and transfers records in a manner that ensures continued access by patients and the College.

The Member maintains and retains records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

In the event of the death of a Member, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another Member, all records are transferred to the purchasing Member and are maintained as above.

If a Member relocates a practice he/she takes the patient records to the new location. If the practice ceases operation, the Member either appropriately transfers or maintains the original of all patient records as described above. Patients are notified in writing as to how they can obtain access to their patient records. The College is also notified and provided with a forwarding address for a minimum of ten (10) years.

In the event of a sale of the practice, all of the original records are transferred to the purchasing Member who maintains those records as described above. Where feasible (in some cases by newspaper notice) patients are notified, in writing, of the practice sale so that any patient who requires it may obtain a copy of their record. The College is also informed in writing of the sale and in whose care and control the original records will be maintained.

In all cases, the College is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Member

9. Dispensing and Selling of Drugs and Substances

The Member creates and maintains appropriate records of the dispensing and selling of drugs and substances for a minimum of ten years.

Performance Indicators

The Member:

- records and maintains an inventory of drugs and substances purchased or received, including date of receipt;
- records the date drugs and substances are dispensed and/or sold;
- records the name of the person to whom the drugs and substances were dispensed and/or sold;

- maintains copies of prescriptions/recommendations from other Members or health care providers;
- maintains a log containing a record of distribution of each drug or substance dispensed to enable the Member to issue a recall of any dispensed drug or substance;
- maintains a record of any product recalls or alerts provided by the manufacturer or Health Canada; and
- maintains these records for a minimum of ten (10) years.

10. Disposing of Patient Records

The Member does not dispose of a record of personal health information unless their obligation to retain the record has come to an end.

Performance Indicators

When the obligation to retain records comes to an end, the records may be destroyed:

- paper or hard copy records must be disposed of in a secure manner such that the reconstruction of the record is not reasonably possible;
- Electronic records must be permanently deleted from all hard drives, as well as other storage mechanisms.
 - Hard drives must either be crushed or wiped clean with a commercial disk wiping utility.
 - Similarly, any back-up copies of the records must be destroyed.

The Members maintains a record of disposal dates, and names of patient whose records were disposed.

Related Standards

Consent

Dispensing

Fees and Billing

Prescribing

Recommending Non-Scheduled Substances

Selling

Legislative Framework

Personal Health Information Protection Act, 2004

Professional Misconduct Regulation

Approval

Original Approval Date: October 15, 2012

Latest Amendment Date: March 6, 2019.

Disclaimer

In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.



The College of Naturopaths of Ontario

Guidelines

Assignment of Care

Introduction

The province of Ontario utilizes the concept of "controlled acts" to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the *Regulated Health Profession Act, 1991* (RHPA). Each profession-specific act, such as the *Naturopathy Act, 2007*, specifies any controlled acts that the members of the profession are authorized to perform (the profession's "authorized acts").

There are also numerous non-controlled procedures which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term assignment refers to the process of a regulated health professional assigning the performance of a non-controlled procedure to another person. The assignment of procedures in appropriate circumstances may allow a more timely and efficient delivery of naturopathic care, making optimal use of time and personnel. In every instance of assignment, the primary consideration should be the best interests of the patient.

Assignment of Care

It is a general expectation that Naturopathic Doctors will be responsible for, and appropriately supervise all assigned activities within their practices. The level of supervision may vary with the risk associated with the assigned procedure. Direct supervision refers to situations in which the Naturopathic Doctor is physically present in the same clinical location. This allows the Naturopathic Doctor to immediately intervene when necessary. Remote supervision refers to situations in which the presence of the Naturopathic Doctor is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any assigned procedure always remains with the Naturopathic Doctor.

Assignment of certain procedures that are not controlled acts may occur as part of the Naturopathic Doctor's examination and may occur prior to the ND assessing the patient. For example, pre-testing using automated instruments may occur prior to the ND seeing the patient.

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the ND. This could include the collection of

information or performance of a physical exam (including taking blood pressure, temperature etc). However the ND is expected to review the results of these procedures and communicate appropriately with the patient.

It is expected that assignment will only occur with certain processes in place, including:

- Education and assessment ensuring the currency of the assignee's knowledge, skill and judgment;
- Documentation/references for performance of procedures; and
- Ensuring only procedures that the Naturopathic Doctor has the knowledge, skill and judgment to perform are assigned.

The Naturopathic Doctor remains responsible for all activity within his/her office, including assigned procedures. It is prudent to always ensure that any activities being assigned are appropriately supervised and performed in a safe, effective and accurate manner.

Good communication skills for both the Naturopathic Doctor and staff members are essential for effective delivery of patient care, particularly when procedures are assigned to another person. Regular staff training, assessment and an effective office policy and procedural manual may be helpful resources to promote competence.

It is also necessary to ensure that the person performing the assigned procedure is clearly indicated within the patient's health record.

Suggested Other Reading

Standard of Practice for Delegation

Standard of Practice for Record Keeping



The College of Naturopaths of Ontario

Guidelines

Referrals and Consultations

Introduction

Access to care is a growing challenge for many patients. The College of Naturopaths of Ontario (CONO) recognizes that every possible measure must be taken to ensure access to timely and effective health care services. Appropriate referral and consultation information, as well as good communication between referring and consulting health care professionals, are essential components of safe patient care. This guide is not intended to replace processes that are already in place. It is an additional resource that may help to fill the gaps, where there are currently few tools to support effective referrals and consultations.

Definitions

Referral: a request from one health professional to another to assume responsibility for management of one or more of a patient's health problems. This may be for a specified period of time, until the problem is resolved or on an ongoing basis. It represents a temporary or partial transfer of care to another health professional for a particular condition. It is the responsibility of the health professional accepting the referral (the consultant) to maintain appropriate and timely communication with the referring health professional. Members are aware that certain situations trigger a mandatory duty to refer as set out in s. 13 of the General Regulation.

Consultation: a request from one health professional to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and/or treatment to the requesting health professional. The requesting health professional may incorporate the consultant's opinion, as well as any other factors (e.g., patient preferences, other consultations, comorbidities) when providing treatment to the patient. A consultant's opinion should not replace the primary health professional's judgment.

Critical Value: A laboratory test result that is communicated by the medical laboratory to the naturopathic doctor indicating a marked deviation from reference ranges, with no clear indication to the laboratory from the naturopathic doctor that these are expected deviations. Results of this nature may indicate a significant risk of a life-threatening event.

A list of tests and critical values can be found in the Ontario Association of Medical Laboratories' Guideline for Reporting Laboratory Test Results.

Mandatory Referrals

Section 13 of the General Regulation under the Naturopathy Act, 2007 includes a series of mandatory referral indicators. That means when certain conditions exist, a naturopath must refer a patient to a physician, nurse practitioner extended class or a member of another appropriate regulated health profession. The conditions include situations where:

- A patient's life is or may be at risk (in such cases, a naturopath must call emergency services and transfer the patient to a hospital).
- A patient's condition prevents the naturopath from communicating a diagnosis because the condition is beyond the scope of practice of the profession.
- Treatment of a patient's condition is beyond the scope of practice of the profession.
- Treatment of a patient's condition requires diagnostic, monitoring or treatment related technology that is beyond the scope of practice of the profession.
- The patient or their authorized representative asks the naturopath to refer the patient to another naturopath, or to a member of another health profession.
- A laboratory test result is a critical value test result, which means it shows a marked deviation from the reference ranges, with no clear indication to the laboratory that these are expected deviations.
- The patient's response to treatment is not adequate and unlikely to improve based on alternative treatments available from the naturopath, or the patient's condition significantly deteriorates and is likely to continue to do so without a referral.

A naturopath who is required to refer a patient is not prohibited from providing supportive or other health services, within the scope of practice of the profession, provided they collaborate with:

- The person to whom the patient was referred.
- The patient.

Referrals (mandatory and non-mandatory) and Consultations

These elements can be applied to any referral, whether mandatory or non-mandatory, and consultation between health professionals. They can also be applied in clinical practice and in the context of service agreements between care providers or facilities.

When a naturopath believes (or where required by law) that a consultation or referral is appropriate, it is recommended that the referring naturopath provide, at a minimum, a written request which includes:

- The specific reason(s) for the consultation/referral;
- Accurate patient contact information (address and phone number);
- Basic demographic information about the patient (gender and age);
- The requesting naturopath's contact information (address, phone number);
- Urgency of the consultation/referral;
- Relevant medical history;
- Current medications and natural health products;
- All relevant test and procedure results.

A copy of the referral/consultation request should be maintained in the patient record.

It is important to note that prior to requesting a consultation or referral, a naturopath must discuss the purpose of the consultation or referral with the patient. The naturopath should ensure that the patient agrees with the release of information, and the choice of health professional to whom a request is being made.

Where a patient does not consent to a referral/consultation or communication, the naturopath must document the discussion, difference of opinion and implications for care in the patient's record. The naturopath should continue to provide care as best as possible within any limits imposed by the patient's decision.

Accepting a Referral Request

A naturopath is not required to accept a referral request. However, if a request for a referral is denied, the naturopath needs to provide the referring health professional with the reasons for denying the referral and, whenever possible, suggestions for alternative health professionals or services that may be available.

When a naturopath receives a request for a referral, it is recommended that the naturopath, at a minimum:

- Provide a prompt written response to the referring health professional within fourteen (14) days;
- Schedule the appointment directly with the patient and send a copy of the appointment information to the referring health professional, unless otherwise agreed;
- Advise the patient of any specific requirements prior to the appointment;
- Communicate expectations about office procedures and policies to the patient (e.g. fees, cancellation policies, etc.).

Where relevant and applicable, it is recommended that a naturopath, within 30 days of completion of the initial assessment (which may take more than one visit), provide the referring health professional with a written report that may include:

- An opening statement outlining the reasons for the referral/consultation;
- An appropriate history related to the problem, including documentation of the relevant positive and negative findings to assist in making a differential diagnosis;
- Any risk factors related to the disease/disorder under consideration;
- A review of systems;
- Family and social histories;
- A review of medications and allergies;
- A complete physical examination of the system of interest;
- A review of available laboratory results, reports of relevant investigations, and any other pertinent patient data;
- A summary of conclusions and recommendations including:
 - The investigations to be done;
 - The potential risks and benefits of each investigation (if applicable);
 - The treatment prescribed or administered, including any changes to existing medications or new medications prescribed, and a list of side effects that were discussed with the patient;
 - The professional advice provided to the patient; and
 - Particulars of any referrals made by the naturopath.
- The follow up plan (e.g., whether the referring health professional or naturopath will follow-up and when the patient is to return for follow up).

It is recommended that subsequent follow-up reports be sent to the referring health professional, within 30 days, when there are new findings or changes are made to the management plan. Follow up reports should include the following:

- A detailed review of the initial problem consulted on and any response to therapy;
- A detailed physical examination related to the system/problem;
- A review of any laboratory reports, consultation reports, reports of investigations performed, and any other pertinent patient data received since the previous visit related to the system/problem; and
- A summary of conclusions, recommendations, and follow up plan.

Copies of Referral/Consultation reports should be maintained in the patient record.

A naturopath who has accepted a referral must obtain informed consent from the patient directly and not defer the consent process to the referring health professional.

It is recommended that a naturopath who has accepted a referral inform the referring health professional when and if the patient has been returned to the original referrer.

Prompt Sheets

These prompt sheets can be used by NDs to support appropriate referrals and consultations.

Referral Prompt Sheet

These are items that you may consider including in a referral request letter, where they are relevant and applicable.

The beginning of the letter/form/email may include the following:

1. Patient's name, address, date of birth, and contact information;
2. Referring naturopath's name and contact information;
3. Health professionals name, address and contact information;
4. Urgency of referral – urgent, semi-urgent, routine or elective.

Other important information that may be relevant:

- Reason for referral;
- Naturopathic diagnosis – confirmed or differential;
- Succinct history of problem related to reason(s) for referral and/or other problems;
- Relevant information on patient's medical status –relevant past history or notes;
- Current and recent medications and/or natural health products;
- Clinical warnings/significant findings on examination;
- Copies of test results;
- What has been communicated to the patient;
- Any possible mitigating factors against particular treatments or arrangements;
- Special considerations (e.g. psychiatric/social problems, need for an interpreter, any other concerns of patient's family);
- Follow-up/role of referring naturopath – who will resume care after the referral.

Finish with a note of thanks for their help in managing the patient.

Consultation Prompt Sheet

These are items that you may consider including in a consultation request letter. The beginning of the letter/form/email may include the following:

1. Patient's name, address, and date of birth and contact information;
2. Requesting naturopath's name and contact information;
3. Consulting health professionals name, address and contact information.

Other important information that may be relevant:

- Reason for Consultation;
- Chief complaint/relevant history;
- Additions to problem list and/or summary of current status of medical conditions;
- Findings – clinical findings on examination, including test results;
- Investigations/interventions;
- Naturopathic diagnosis – confirmed or differential;
- Treatments and management plan:
 - Goal of treatment;
 - Options considered and supported/not supported;
 - Recommended treatment and management;
 - Proposed treatment schedule with reasons;
 - Anticipated benefits and risks of treatment;
 - Changed or newly prescribed medication(s) and/or natural health products;

- Likely short and long-term complications;
- Possible effects of treatment on patient's quality of life and functional capacity;
- Contingency plans in case of adverse events from (or failure of) first choice treatment.
- Prognosis;
- Psychosocial aspects (e.g., patient's understanding, psychiatric/social problems);
- Follow up arrangements (who and when to review the patient following consultations, including any situations with may prompt an earlier or additional review).

Finish with a note of thanks for their help managing the patient.

References

College of Physicians and Surgeons of Ontario. Policy Statement #4-12, Medical Records. Updated May 2012.

College of Physicians and Surgeons of Alberta. The Referral Consultation Process, Standard 6. January 2012

College of Physicians and Surgeons of Nova Scotia. Guidelines for Physicians Regarding Referral and Consultation. March 2010

Royal College of Family Physicians of Canada. Guide to Enhancing Referrals and Consultations Between Physicians. October 2009.

Ontario Association of Medical Laboratories. Guideline for Reporting Laboratory Test Results

Legislative Framework

Professional Misconduct Regulation

General Regulation

Relevant Standards & Guidelines

Consent

Record Keeping

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

SALFE ANNE ELIZALDE

DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS
OF ONTARIO

**AGREED STATEMENT OF FACTS AND
ADMISSION OF PROFESSIONAL
MISCONDUCT**

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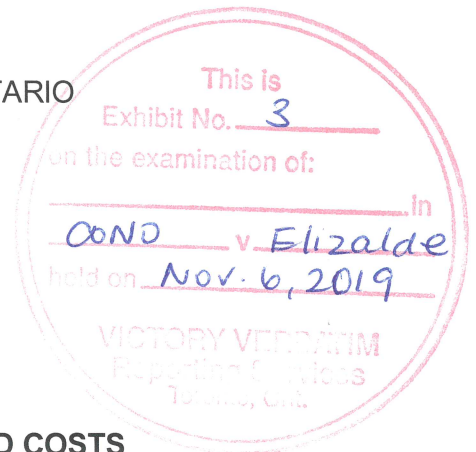
**DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF ONTARIO**

BETWEEN:

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

SALFE ANNE ELIZALDE



JOINT SUBMISSION AS TO PENALTY AND COSTS

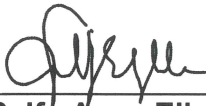
The College of Naturopaths of Ontario and Dr. Salfe Anne Elizalde, ND (the "Member") agree and jointly submit that the Discipline Committee make an order:

1. Requiring the Member to appear before the panel to be reprimanded immediately following the hearing of this matter.
2. Directing the Registrar to suspend the Member's certificate of registration for a period of five months, on a schedule to be set by the Registrar, two months of which shall be remitted if the Member completes the provisions of paragraph 3(a) through 3(d) no later than January 31, 2020.
3. Directing the Registrar to impose the following specified terms, conditions and limitations on the Member's certificate of registration:
 - a. Requiring that the Member unconditionally pass the PROBE ethics course, which is to be taken at her own expense, no later than February 29, 2020.
 - b. Requiring that the Member successfully complete, to the satisfaction of the Registrar and at her own expense, the College Jurisprudence Course no later than February 29, 2020;

- c. Requiring that the Member successfully complete, to the satisfaction of the Registrar and at her own expense, a medical records course, approved by the Registrar, no later than February 29, 2020;
 - d. Requiring that the Member write an essay between 1000 and 1500 words in length, and provide it to the Registrar no later than February 29, 2020, that shall be published by the College at a time and in a format determined by the Registrar, on the following issue:
 - i. The lessons she learned in completing the PROBE, College Jurisprudence and medical records courses.
- 4. Requiring the Member to pay a fine of not more than \$350 to the Minister of Finance within one (1) month of the date of the Order.
 - 5. The Member shall pay the College's costs fixed in the amount of \$4,000 payable within thirty days of the date of the hearing or on schedule set by the Registrar.
 - 6. The Member acknowledges that this Joint Submission as to Penalty and Costs is not binding upon the Discipline Committee.
 - 7. The Member understands and acknowledges that she is executing this document voluntarily, unequivocally, free of duress and free of bribe and that she has been advised of her right to seek legal advice.

All of which is respectfully submitted,

Signed this 30th day of October, 2019



Dr. Salfe Anne Elizalde, ND
Member

Signed this 31st day of October, 2019



Andrew Parr, CAE
Registrar & CEO
College of Naturopaths of Ontario

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

SALFE ANNE ELIZALDE

DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS
OF ONTARIO

JOINT SUBMISSION AS TO PENALTY
AND COSTS

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**DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF ONTARIO**

BETWEEN:

COLLEGE OF NATUROPATHS OF ONTARIO

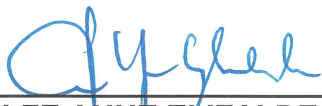
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SALFE ANNE ELIZALDE

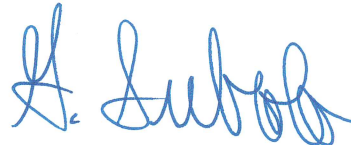
NOTICE OF WAIVER

The undersigned hereby waives all rights of appeal pursuant to section 70 of the *Health Professions Procedural Code* of the *Regulated Health Professions Act, 1991* with respect to the findings and the order of a reprimand made by the Discipline Committee of the College of Naturopaths of Ontario on November 6, 2019.

Dated at Toronto, Ontario this 6th day of November, 2019.



SALFE ANNE ELIZALDE



Witness

Name of Witness: Gary Szebrolov

