PATIENT CONSENT FORM

I______________________________, hereby request and consent to Chiropody treatment. I give the Chiropodist permission to perform, necessary examinations and assessments, as well as diagnostic procedures as may be deemed necessary, in order to provide me with the best quality foot care. I consent to photographs to be taken by the Chiropodist and/or anyone working in this clinic authorized by the Chiropodist.

I understand that all my personal information is confidential and will be used for no other purpose than for the chiropodist's clinical records and to comply with legal and regulatory requirements of The College of Chiropodists of Ontario. However, I allow and consent to the Chiropodist to send a report to my physician regarding my foot exam and treatment. We promise to treat your personal information with respect. Our privacy protocols comply with privacy legislation, the standards of the College of Chiropodists of Ontario and the law.

I understand and am informed that, as in all health care, in the practice of chiropody there are some very slight risks to treatment, including, but not limited to pain, swelling and infection. I do not expect the Chiropodist to be able to anticipate and explain all risks and complications and I wish to rely on the Chiropodist to exercise judgement during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known is in my best interest. I further understand that I may withdraw my consent and request to terminate or modify the treatment at any time.

Payment for any chiropody visits are to be paid on the day of service. **The initial visit fee of $95.00 is due upon day of consultation**. Any fees for subsequent appointments will be discussed. I understand that I am financially responsible for all charges whether covered by my health insurance plan or not and are payable at the time service is provided.

I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to treatment by the chiropodist. I intend for this consent form to apply to the entire course of my treatment, including today and any other future visits.

Please initial _____________

ATTENDANCE POLICY

The Toronto Foot Clinic is committed to providing you with the highest quality foot care and therefore, it is important that you keep your appointments. We like to accommodate everyone but missed appointments and late cancellations prevent us from being able to help everyone in a timely manner. Your appointment time is held for you. Please understand that a missed appointment or late cancellation prevents another client from accessing our services. ***As a result, cancellations less than 24 hours (unless an emergency), missed appointments or no-shows will be subject to a $50.00 fee.***

Please be on time for your appointment. If you are late, you may not be seen, and we may have to reschedule your appointment. If you arrive late and are seen, your appointment may be shorter, and we may not be able to provide you with the care that you need. I understand all fees for cancellations/missed appointments are the patient's responsibility.

I have read the above Consent Form and Attendance Policy and understand that my cooperation and active participation directly relates to my foot health.

____ _____________

Signature of patient **Date**

If patient is under the age of 16:

_____________________________ __________________________ _____________

Parent/Guardian (Print name) **Parent/Guardian (Signature)** **Date**