



MEDICAL CONSENT UPDATE

Seagate2021

Name: _____ Date of Birth: _____ YYYY _____ MM _____ DD
 Address: _____
Preferred Contact Method: (Please circle one) Email: _____
 Phone: Home #: _____ Cell #: _____ Work #: _____
 Family Physician: _____ Address: _____
 Current Foot Problem: _____

LIST MEDICAL CONDITIONS	LIST CURRENT MEDICATIONS	<input type="checkbox"/> LIST ATTACHED
Do you take a blood thinner? <input type="checkbox"/> NO <input type="checkbox"/> YES-name of blood thinner?		
ALLERGIES: <input type="checkbox"/> NONE KNOWN List Allergies:		

PATIENT'S CONSENT: Please initial on each line below confirming you have read the consent

	<p>Patient appointments are high in demand and vary in degree of time requirement and level of care. The attending Chiropodist will kindly advise you of your management plan that includes an appropriate time frame for rebooking. I consent to treatment by the Chiropodist available at my appointment time which may differ from the original Chiropodist booked and accept the best appointment availability provided by booking staff.</p>
	<p>This is a zero tolerance office that strictly prohibits verbal abuse and harassment, abusive language aggressive behaviour, bullying and sexual harassment. I understand that I will be banned from the clinic if this behaviour is noted.</p>
	<p>I allow photographs of treatment areas to be taken for the purposes of monitoring and education.</p>
	<p>I consent/allow the Chiropodist to contact and/or send my Physician or health care professional any pertinent information required regarding my foot exam and/or treatment plan or medical information.</p>
	<p>I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service fees are payable at the time service is provided. I understand that it is my responsibility to attend my scheduled appointment and in the event of missing the scheduled appointment without 24 hours' notice, I will be responsible for a missed appointment charge of \$40.00.</p>

Patient's Signature): _____ Date: _____

Guardian Signature: _____ Relationship: _____

Print Name of Guardian: _____

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. Be assured that everyone in our office is committed to ensuring that you receive the best quality foot care.