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 understand that all of 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.

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 interests.

I further understand that I may withdraw my consent and request to terminate or modify the treatment at any time.

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 NOTE: FAILURE TO GIVE 24 HOURS NOTICE OF A CANCELLATION WILL RESULT IN A FEE.

____________________________________  ___________________________
Signature      Date

____________________________________  ___________________________
Signature of Parent or Guardian   Date