FOUNDATION CHIROPODY

CONSENT FOR COLLECTION OF PERSONAL INFORMATION & CONSENT FOR TREATMENT

This office will only collect, use and disclose information about you for the following purposes;

1. To deliver safe and efficient patient health care and To identify and ensure high quality service is provided to our patients on a continuous basis
2. To assess your foot health needs and to advise you of treatment options appropriate to those specific needs
3. To enable us to contact you and maintain communications with you to ensure that your podiatric servicing needs are adequately met on an ongoing basis
4. To offer and provide treatment, care, information or services related to your general and specific foot health care needs
5. To communicate with your other health care providers including your family physician or outside laboratory services when necessary and appropriate
6. To contact you to distribute health care information, to book or to confirm appointments
7. To contact you to efficiently follow up on treatment, quality of care and payment
8. To complete and submit podiatric claims for third party adjudication and payment
9. To comply with legal or regulatory requirements under the *Regulated Health Professions Act,* the Health professions Procedural Code, the *Chiropody Act,* and associated regulations
10. To prepare materials for the Privacy Commissioner and / or our liability insurance carrier as required
11. To permit purchasers (or agents) to evaluate and audit the Chiropody practice in preparation for practice sale
12. To invoice for goods and services, to process credit / debit card payments or to collect unpaid accounts
13. To allow this office to comply with all regulatory requirements and with the laws of Ontario and Canada

By signing this Consent Form, you agree that you have given your informed consent to the collection, use and or disclosure of your personal information for the purposes that are listed. Your information may be accessed by the College of Chiropodists of Ontario or other regulatory authorities acting under statute, or in defense of a legal issue. We will seek your approval, in advance, if a new purpose arises for the use and/or disclosure of your personal information unless the use or disclosure is required by law. You may withdraw your consent for use and disclosure of your personal information, and we will explain the process for doing so and ramifications of that decision. I have reviewed the above information that explains how Foundation Chiropody will use my personal information. I also understand that Foundation Chiropody safeguards my personal information and that I can have access to it. I agree that Foundation Chiropody can collect, use and disclose personal information about the undersigned as set out above.

I hereby give consent for the examination, assessment and treatment of my own feet OR my (parent's/son's/daughter's) feet. I understand that all procedures involved in the examination, assessment and treatment(s) will be explained to me by the attending Chiropodist. I am also aware of the fee for service and assume responsibility for the cost incurred. Special consents may be required as needed.

Print Patient Name:	**Patient Signature:**	**Date:**
Guardian Name:	**Guardian Signature:**	**Date:**
Witness Name:	**Witness Signature:**	**Date:**

Since Foundation Chiropody provides medical services and medical devices we do not issue refunds once services and devices have been provided or prescribed. Any defects in devices such as orthotics or shoes are however covered by the individual manufacturer's warranties. As a client/patient you are responsible for understanding this upon purchasing any item at our clinic.

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REGISTRATION FORM

Today's Date: mm/dd/yy ____/____/____

Patient's last name	**First**	**Middle**	**Birth Date:** mm/dd/yy ____/____/____
Shoe Size: Shoe Width:		Height: Weight:	Age:
What kind of shoes do you wear mostly: ☐ Dress		☐ Sport	☐ Work boots/steel toes
Street address:		Home Phone :	Mobile phone :
Suite/P.O. box:	City:	Province:	Postal Code:
Occupation:	Employer:		Work Phone: ( )
Email:		Sports/Activities:	
Family Physician:		Address :	Phone :

HEALTH HISTORY

What is the nature of your foot problem today?		
LIST ALL PREVIOUS MEDICAL DIAGNOSIS, RECENT HOSPITAL VISITS, SURGERIES, PREVIOUS FOOT/LEG FRACTURES		
Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF SO WHAT YEAR?	☐ Yes	☐ No

LIST PRESCRIBED MEDICATIONS	**LIST ALLERGIES TO MEDICATIONS/FOOD**

DO **YOU** HAVE ANY OF THE FOLLOWING CONDITIONS? (circle item and check box)		
(EYES/EARS) glaucoma, cataracts, discharge from ears, severe hearing or vision impairment, **other**:	☐ Yes	☐ No
(RESPIRATORY) chronic shortness of breath, asthma, emphysema, chronic bronchitis, **other**:	☐ Yes	☐ No
(CARDIAC) high cholesterol, chest pain, angina, heart attack, congestive heart failure, elevated blood pressure:	☐ Yes	☐ No
(GI/UROGENITAL) kidney disease, stones, gallbladder, rectal cancer, ulcers, liver disease, frequent urination	☐ Yes	☐ No
(ENDOCRINE) diabetes, hyperthyroidism, hypothyroidism, Cushing syndrome, Addison's disease, **other**:	☐ Yes	☐ No
(VASCULAR) varicose veins, anaemia, blood clots, stroke , Berger's disease, Raynauds , bleeding disorders,	☐ Yes	☐ No
(MUSCULO-SKELETAL) recent muscle weakness or loss of muscle bulk, osteoarthritis, rheumatoid arthritis, osteoporosis, muscular dystrophy, multiple sclerosis, back problems, **other**:	☐ Yes	☐ No
(NEUROLOGICAL) frequent dizziness, frequent severe headaches, lack of sensation in the feet, history of spinal or head trauma, cerebral palsy, polio, Parkinson's, epilepsy Alzheimer, **other**:	☐ Yes	☐ No
(DERMATOLOGICAL/SKIN) psoriasis, eczema, chronic athletes foot, **other**:	☐ Yes	☐ No
Are you being treated for any psychiatric or emotional conditions?	☐ Yes	☐ No

I have a family history of the following medical conditions:

Additional relevant information: