A Step Ahead
Foot Clinic

James Beard, D.Ch & Associates

Registered Chiropodists – Foot Specialists

HEALTH CONSENT FORM & CANCELLATION POLICY

Name of Patient: _____ Date of Birth: _____
Name of Chiropodist at First Visit: _____ (to be completed in office)

Please indicate consent by placing initials in the boxes below.

CONSENT FOR TREATMENT

☐ I provide consent for assessment and treatment (including various modes of physical therapy) by the Chiropodist and/or support staff, and also to photographs to be taken for the purposes of monitoring.

COST OF OUR SERVICES

☐ I understand that I am financially responsible for all fees and that these are payable at the time the service is provided. Receipts will be issued to claim reimbursement from health plans or for income tax purposes. An appointment fee will be applied for appointments cancelled with less than 24 hours notice and for missed appointments.

CONSENT FOR OBTAINING, COLLECTING AND RELEASING PERSONAL INFORMATION

☐ I authorize A Step Ahead Foot Clinic to request/release medical information regarding my diagnoses, treatment and prognosis from/to persons relevant to my care (physicians/health care providers/ funding sources/etc).

☐ I understand that the personal information collected/released by A Step Ahead Foot Clinic (in paper/electronic/photograph form) will be treated with respect and comply with Privacy Legislation, the Standards of the College of Chiropodists of Ontario, and the Law. I understand that I may view A Step Ahead Foot Clinic's Privacy Policy on request.

We would like to use email communications for your convenience, office efficiency, and environmental responsibility.

☐ Please indicate your consent and provide your email address: _____

PATIENT'S SIGNATURE: _____

DATE: _____

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