**PATIENT CONSENT FORM**

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| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: \_\_\_\_\_dd \_\_\_\_\_\_\_mmm \_\_\_\_\_\_\_\_\_\_ yyyy |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Fees for Payment/Consent for Treatment** |
| **We accept cash, cheque, credit card** |  |  | **\*NSF of $50 for returned cheques and no shows or cancellations in less than 24 hours** |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(patient’s name)* feel I have been given the opportunity to review information and discuss details of my assessment results, recommendations, including nature treatment, indications, expected benefits, risks and side effects, alternative course of actions, and likely consequences of not having treatment prior to receiving treatment.

Therefore, I consent to one or all of the following treatments by licensed or registered nurses that carry personal liability insurance, and who use best practices including the use of one-time use or sterilized instruments:

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| * Assessments of medical history
 | * Debridement of wounds
 | * Reduction of nails
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| * Moisturizer application
 | * Assessment of lower legs
 | * Reduction of callouses or corns
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| * Foot care health teaching
 | * Assessments of footwear &/or orthotics
 | * Handouts and samples
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| * Treatment of wounds
 | * Digital photos of my feet/wounds
 | * Product recommendations
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| * Referrals to other health professionals
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**Secure storage, retention and authorized release of client information**

All information is collected and stored under the strict guidelines of the Health Information Act of Alberta in order to obtain and protect your confidentiality.

By signing this consent, the individual or representative, gives \_\_\_\_\_\_\_\_ permission to discuss medical assessments, services, treatments, photos with your physician, facility medical personnel or insurance company as applicable.

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| Patient’s Signature: |  |
| Patient Representative *(print name):* |  |
| Patient Representative’s Signature |  |
| Relationship to patient: |  |