Sole Foot Care & Wellness

Gibbons, AB

Phone: ( 587) 357-1929

Email: solefootcareandwellness@gmail.com

Website: www.solefootcareandwellness.com

**Consent to Treatment Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby voluntarily consent to the rendering of care, provided by Tonice St.Jean, LPN, Advanced Foot Care Nurse, in the Province of AB, Canada.

I have received the following information:

INFORMED CONSENT – PROCEDURE/TREATMENT

1. I understand what Tonice St.Jean can and cannot do, and I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered, and I understand the inherent (specific) risks of the procedures/treatments I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.
2. I consent to being photographed before, during, and after the procedure(s) or treatment(s), including appropriate portions of my body, for medical, documentation or educational purposes, provided my identity is not revealed by the pictures. And I consent that these images may be used for marketing purposes.
3. It is possible for Sole Foot Care & Wellness to share my assessment and treatment documentation with my family doctor or other medical/nursing professionals they work with. I consent that this documentation be shared with other health professionals.
4. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
5. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
6. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
7. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS

(1-4).

I AM SATISFIED WITH THE EXPLANATION

**By signing this form, I acknowledge and consent to the information contained in it.**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_