Sole Foot Care & Wellness

Gibbons, AB

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Provider's Documentation of Informed Consent for Foot Care Services

**Patient Name:**

**PHN:**

**Family Doctor Name and Clinic Name:**

**Date Of Intake:**

**Primary Concern:**

***\*Please read the following carefully and initial on the line. Don't hesitate to ask any questions\****

***The Following Procedures and Assessments May Be Completed During This Appointment:*** Review of Medical History, Lower Legs, Footwear And/or Orthotics, Digital Photographs to Track Progress of Care, Patient Education, Trimming And/or Filing of Toenails, Reduction of Corns and Calluses, Moisturizer Application. \_\_\_\_\_\_\_\_\_\_

***Tools That May Be Used during treatment:*** Curettes, Scalpels, Rotary Tool, Files, Nippers. \_\_\_\_\_\_\_\_\_\_

***Risk Of Procedures:*** There Is a Minor Risk of Skin knicks, Bleeding, Pain, Swelling And/or Infection. \_\_\_\_\_\_\_\_\_\_

***Reducing Risk:*** While advanced foot care nurses have additional training to support their foot care practice and use disposable (one-time use) or reusable sterilized equipment to reduce the risk to you, risk is not completely eliminated. \_\_\_\_\_\_\_\_\_\_

***Information Gathering:*** Any personal information collected is confidential and will be maintained through the electronic medical records app, CompanyOn, which abides by the Personal Information Protection and Electronic Documents Act (PIPEDA). \_\_\_\_\_\_\_\_\_

***Permission To Share Information:*** If medically necessary or to enhance care, information from this service may be shared with other care providers, including but not limited to your physician. \_\_\_\_\_\_\_\_\_\_

***Payment:*** Insurance will not be directly billed for this service, unless previously discussed during booking. Payment is required immediately after services are rendered. Receipts for services are available upon request. Receipts are necessary to receive a refund from your insurance company, if foot care services are covered through your plan. \_\_\_\_\_\_\_\_\_\_

***Discontinuing Services:*** The Patient Is Free to Discontinue Services at Any Time. \_\_\_\_\_\_\_\_\_\_

***Questions:*** The patient is encouraged to ask and have answered, to their satisfaction, any questions related to this service. \_\_\_\_\_\_\_\_\_\_

**Free And Informed Consent Has Been Obtained From:**

 Patient

Patient Delegate (who acts on behalf of the patient)

**Delegate's Full Name and Relation to Patient:**

**Obtained By:**

 Provider's Name:

**Provider's Signature:**