At Your Feet Inc.
Nursing Foot Care
408 West 5th St.
Hamilton, ON
L9C 3P6
T: 905-575-6539 F: 905-667-5476

PATIENT CONSENT FORM

I _____, signing for _____, hereby authorize At Your Feet Inc. (from here on referred to as AYF) registered staff, to perform nursing foot care on the above-mentioned person's feet. I realize that a hospital call is $100 base rate (up to 45 mins, $2/min if extra time required) ($25 extra if in isolation)

To the best of my knowledge is the person mentioned above in isolation? Yes or No (Please circle)

I certify that the treatment or procedure has been explained to me by AYF staff and understand that no guarantee has been made or offered to me regarding the treatment provided.

I consent to the taking of photographs during the course of my treatment for documentation purposes, to aid in treatment, and for scientific, educational and instructional purposes.

I authorize AYF staff to share any relevant information regarding my care with my doctor or health care professional, while under the care of AYF.

I authorize AYF staff, that while under their care, should any condition be discovered during my treatment or in any case of emergency, to do whatever is necessary to alleviate my condition.

If for any reason the person named above is released or moved from the hospital, it is the responsibility of above named person or their POA to inform AYF staff immediately. If AYF is not notified within 24 hours prior to their appointment, charges will not be refunded.

I certify that I _____, have read/had read to me this consent form and I fully understand all that I have read/was read to me.

☐ I would also like to receive fingernail care, at a charge of $30 extra.
(Please initial)

_____ _____

Signature of Patient/Power of Attorney **Date**