New Tecumseth
Family Footcare
A Step Toward Better Health

Division of 1194466 Ontario Ltd.

Office Policy - Please read carefully before signing.

Chiropody Information and Fee Schedule:

- The practice of Chiropody is the assessment of the foot and the treatment and prevention of disease, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means and governed by the College.
- Chiropody services and orthotics are covered by many private health insurance plans, WSIB, and Veterans Affairs Canada. Chiropody services are not covered by OHIP, so please check your plan for details.
- Fees for Service, Orthotics and Footwear is based on the Canadian Federation of Podiatric Medicine and The Ontario Society of Chiropodists Fees Schedule and is subject to annual change.
- Sample of fees: Initial Assessment $25 plus Consultation or Treatment fee; Reassessment after 1 yr. or New Incident $20 plus treatment fee; Subsequent Visits Consultation or Treatments starts at $50; Cryosurgery Fee $75 plus $15 for additional satellite locations; Photo Therapy (Laser) Treatment Initial $75, Subsequent single location $60; Orthotics Fees: range $525-$570 per pair, includes case fee and warranty, please inquire for additional pairs; Compression legwear, Therapeutic Sandals or Prescription Orthopaedic/Therapeutic Footwear Fees vary (modifications extra), fees are subject to annual increases and may change without notice.

Appointment Policy:

- New Tecumseth Family Footcare is committed to providing you with the highest quality footcare and therefore, it is important that you keep your appointments.
- We will do our best to see you in a timely manner and ask that you please arrive five minutes before you scheduled appointment time to ensure your full allotted time and because it shows respect for other patients.
- Appointment times vary, so please inquire. We advise that you call ahead to schedule a time with the chiropodist as we are often booked in advance and may not be able to accommodate last minute appointments.
- We understand that sometimes events happen that require cancelling of your appointment and therefore a minimum of 48 hours' notice (Monday – Friday) must be given. Cancellation otherwise is considered a No-Show and repeated No-Show clinical appointments will lead to restrictions on advanced bookings and a No-Show fee.
- We reserve the right to refuse treatments to anyone not adhering to clinic policies or with an outstanding balance; the chiropodist may terminate or conclude the treatments or future treatments without a refund.

6B-50 Main Street East, Beeton, ON. L0G 1A0
Tel. 905-729-0782 Fax 905-729-4009

PATIENT CONSENT FORM

I _____, hereby request and consent to Chiropody treatments. I give the Chiropodist permission to perform, necessary examinations and assessments, as well as diagnostic procedures as may be deemed necessary, in order to provide me with the best quality foot care. I consent to photographs to be taken by the Chiropodist and/or anyone working in this clinic authorized by the Chiropodist.

I hereby understand that Chiropody treatments are fee for service, and I am responsible for payment of all services and fees at the time of service. Payment is accepted in the form of cash, Debit, Visa and Master card.

I understand that all my personal information is confidential and will be used for no other purpose than for the Chiropodist's clinical records and to comply with legal and regulatory requirements of The College of Chiropodists of Ontario, Medical Physician, or Insurance Company regarding my file.

I understand and am informed that, as in all health care, in the practice of chiropody there are some very slight risks to treatment, including, but not limited to pain, swelling and infection. I do not expect the Chiropodist to be able to anticipate and explain all risks and complications and I wish to rely on the Chiropodist to exercise judgement during the course of the treatment which the chiropodist feels at the time, based upon the facts then known is in my best interest. I further understand that I may withdraw my consent and request to terminate or modify the treatment at any time.

I have read the above consent; I have had the opportunity to ask questions about its content, and by signing below I agree to treatment by the Chiropodist. I intend for this consent form to apply to the entire course of my treatment, including today and any other future visits.

Patient's Signature: _____ Date: _____

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