PATIENT INFORMATION

(Please Print)

Name_____ Male ☐ Female ☐

Address_____ Email:_____

Street Apt. #

City_____ Postal Code_____ Occupation _____

Family Physician:_____

Date of Birth____/____/____

m d yr

Telephone Number (H)_____(W) _____(Cell)_____

How did you hear about our office? ☐ Yellow Pages ☐ Website ☐ Friend ☐Other_____

Referred by: ☐ Doctor ☐ Existing Patient ☐ Self

Emergency Contact:_____Relationship:_____ Telephone Number:_____

PLEASE DESCRIBE your foot problem: _____

Have you had any of the following illnesses?

	Yes	No
1. Heart problems	☐	☐
2. Stroke	☐	☐
3. Rheumatoid Arthritis	☐	☐
4. Polio	☐	☐
5. Gout	☐	☐
6. Psoriasis	☐	☐
7. Diabetes	☐	☐
8. History of ulcers or gangrene in the leg/foot/toes	☐	☐
9. Hepatitis	☐	☐
10. Sexually transmitted disease	☐	☐

State if you have any medical conditions not listed above:_____

Are you allergic or have any known allergies to local anesthetic?	☐	☐
Have you ever had local anesthetic? If yes, please list_____		
If required I consent to the administration of a local anesthetic.	☐	☐
Are you presently taking any medications?	☐	☐
If yes, please list:_____		
Are you allergic to any medication?	☐	☐
If yes please list_____		
Have you ever fainted?	☐	☐

Have you ever had any foot surgery or foot problems? Yes ☐ No ☐

If yes, when and where:_____

What kind of shoes do you wear? ☐Oxfords ☐ Slip-On ☐Runners ☐Walking ☐Work Boot ☐Dress Shoes

		Yes	No
Do you have coverage through:	**WCB**	☐	☐
	DVA	☐	☐
	First Nations	☐	☐
	Community and Social Services	☐	☐

I grant permission for a consultation/assessment letter to be sent to the referring practitioner following my appointment, at the discretion of the Chiropodist. Yes ☐ No ☐

I consent to the use of my email for Foot Works' monthly educational Enews which provides valuable information such as foot care tips, service updates and upcoming events. Yes ☐ No ☐

I understand that Chiropodists are not medical doctors and that, although we provide treatment of foot and associated pathologies to our highest abilities, your family physician is responsible for overall health care. We encourage you to consult your doctor about all your health care.

I hereby state that the above information is true to the best of my knowledge and I understand this is a fee for service practice, which is NOT covered by O.H.I.P.

Signature_____ **Date**_____

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality foot care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients. In this office, Stephen Hartman acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation privacy protection protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropodists of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality foot care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information. This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the chiropody/podiatry scope of practice
- to communicate with other treating health-care providers, including specialists and general practitioners who are the referring practitioners
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit foot claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Chiropodists of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act

- to comply with agreements/undertakings entered into voluntarily by the member with the College of Chiropodists of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the foot practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the chiropodist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions and Appeal Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply with the general law

By signing the consent section of the Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Chiropodists of Ontario fulfilling its mandate under the RHPA, and for the defence of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact your for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Stephen Hartman can collect, use and disclose information about _____ (patient name) as set out above in the information about the office's privacy policies.

_____ _____

Signature Print name

_____ _____

Date Signature of witness