



Medical Foot Care

CLIENT INTAKE FORM



Today's Date _____

Name _____

Date of Birth Month _____ Day _____ Year _____ Mobile Phone # _____

Address _____

Occupation _____ Occupation before retired _____

Email _____

Do you have Extended Health Benefits? ☐ Yes ☐ No

If yes, please what is the name of your insurance provider? _____

Emergency contact person _____ Relationship _____

Emergency contact phone # _____

Who is your Primary Care Provider (PCP)? _____

What city does your Primary Care Provider practice in? _____

Do you see a specialist? ☐ Yes ☐ No

If yes, for what type of care? _____

Are you taking medication? ☐ Yes ☐ No If yes, please provide pharmacy list to reception to make a copy

Do you have any allergies? ☐ Yes ☐ No

If yes, please list _____

How did you learn about our clinic? _____

Have you received Medical Foot Care before? ☐ Yes ☐ No

If yes, where? _____

What are your concerns you wish to be treated for?

- | | | |
|--|--|--|
| ☐ General Medical Foot Care | ☐ Cracked Skin on Feet | ☐ Orthopedic Shoes |
| ☐ Toenail Care | ☐ Wart Laser Removal | ☐ Lower Limb Swelling |
| ☐ Ingrown Toenail | ☐ Diabetic Foot Care/Screening | ☐ Compression Socks |
| ☐ Toenail Infection (Laser) | ☐ Wound Care/Healing | ☐ Detox Foot Cleanse |
| ☐ Callouses/Corns | ☐ Foot Pain-Therapeutic Laser Treatment | ☐ Foot Reflexology |
| ☐ Cracked Heels | ☐ Custom Foot Orthotics | |



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Have you been Diagnosed by your Primary Care Provider (PCP) with any of the following conditions:

- | | | |
|--|---|---|
| ☐ Diabetes | ☐ Stroke (CVA, TIA) | ☐ Plantar Faciitis |
| ☐ High Blood Pressure | ☐ Peripheral Arterial Disease | ☐ Arthritis |
| ☐ High Cholesterol | ☐ Blood Clots | ☐ Toenail Fungus |
| ☐ Heart Condition (M.I.) | ☐ Have you had the COVID Shot? | ☐ Athletes Foot |
| If yes, do you have a pacemaker? | ☐ Peripheral Neuropathy | ☐ Eczema |
| ☐ YES ☐ NO | ☐ Vitamin B Deficiency | ☐ Psoriasis |

Do you have other conditions you believe we should know about?

Please take a moment to read our general clinic policies & procedures

- We do not direct bill to private health insurance however, make every effort to assist you with coverage and encourage you to check directly with your insurance to determine coverage.
- Our services are usually billed under “nursing services” through extended health insurance plans or “flex” plans.
- Our services are not covered by OHIP
- Payment is due once care is rendered and we will provide you with a receipt to submit to your extended health insurance plan or can be used on your income tax return.
- We are able to submit your service to Blue Cross or Greenshield on your behalf who will reimburse you directly based on how you have set up your plan with these two providers.
- Please ensure you set aside a full hour for your appointment.
- 48 hours notice of cancelation or rescheduling is required to avoid missed appointment fee's.
- Custom foot orthotics, compression socks/stockings and services rendered are non-refundable.
- Custom foot orthotics can be modified however, there is a \$100.00 lab and shipping fee required.



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CLIENT CONSENT



Your personal health information is kept strictly confidential as per the Personal Health Information Protection Act (PHIPA). We encourage confidentiality and will never release your personal health information without your consent.

Please carefully read below when considering the release of your information.

1. Do you consent to allowing our clinic to share your personal health information to your **primary care provider?**

For example: sending our assessments to gain insurance coverage for the care or products you require from our clinic. Some insurance companies will ask for approval from your PCP in order to reimburse you for care.

☐ YES ☐ NO

2. Do you consent to allowing our clinic to share your personal health information with the **government officials?**

☐ YES ☐ NO

3. Do you consent to allowing our clinic to share your personal health information with **Public Health without your prior knowledge?**

☐ YES ☐ NO

3. Do you consent to allowing our clinic to share your personal health information with a **regulatory college without your prior knowledge?**

☐ YES ☐ NO

By signing this form, you are giving consent to our Registered PodOrtho Foot Specialists, Nurses and other Healthcare Providers to perform treatments for you at *YOUR COMPANY/CLINIC NAME HERE*, agree to and understand the above clinic policies and procedures and have been given the opportunity to ask questions with administrative staff if unsure.

Client Signature _____ Printed Name _____

Administrative Section

Clinic Staff Witness Signature _____ Printed Name _____

Date _____