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PRIVATE CHIROPODY / PODIATRY CONSENT FORM

I / We hereby request and consent to private Chiropody treatment. I / We 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 / resident with the best quality foot care.

I / We understand that all personal information is confidential and will be used for no other purpose than for the chiropodist's / podiatrist's clinical records and to comply with legal and regulatory requirements.

I / We understand and am informed that, as in all health care, in the practice of chiropody / podiatry there are some very slight risks to treatment, including, but not limited to pain, swelling and infection.

I / We do not expect the chiropodist/podiatrist to be able to anticipate and explain all risks and complications and I wish to rely on the chiropodist / podiatrist to exercise judgement during the course of the procedure which the chiropodist / podiatrist feels at the time, based upon the facts then known, is in my best interests.

I / We further understand that I / we may withdraw my consent and request to terminate or modify the treatment at any time.

I / We have read the above consent. I / We intend for this consent form to apply to the entire course of any treatment undertaken.

I / We give consent	
I / We do not give consent	

Name of Resident: _____

Resident / POA / Relative signature: _____

Name (in block capitals) _____

Date: _____