ACADEMY FOOT & ORTHOTIC CLINICS

Confidential Patient Information

DATE:

LAST NAME: FIRST NAME: MIDDLE NAME:

ADDRESS: APT #

CITY: PROV: POSTAL CODE: HOME TEL:

BIRTH DATE d/m/y: AGE: MALE / FEMALE WORK TEL:

MARITAL STATUS: M/S/W/Div/ COM-LAW # OF CHILDREN: CELL TEL:

IF MINOR, NAME OF PARENT OR GUARDIAN: EMAIL:

OCCUPATION: WHAT IS YOUR PREFFERRED METHOD OF CONTACT? *(HOME) (CELL) (WORK) (EMAIL)*

COMPANY NAME:

IF STUDENT, NAME OF SCHOOL, GRADE/YEAR:

VISA/MC #: EXPIRY DATE:

REASON FOR TODAY'S VISIT:
(Please Circle)
ORTHOTICS - CORNS - DIABETIC CARE - NAIL CARE - PAIN -PLANTAR WARTS - SKIN PROBLEM
OTHER:

HOW LONG HAVE YOU HAD THIS CONDITION(S):

HAVE YOU HAD PREVIOUS PODIATRY CARE?

IF YES : WITH WHOM: WHEN:

NAME OF YOUR FAMILY DR: PHONE #:

REFERRED BY(circle): INTERNET – LOCATION – SIGN – YELLOW PAGES – FRIEND – FAMILY – DOCTOR
OTHER:

IF BY INTERNET: SEARCH ENGINE USED: SEARCH WORD:

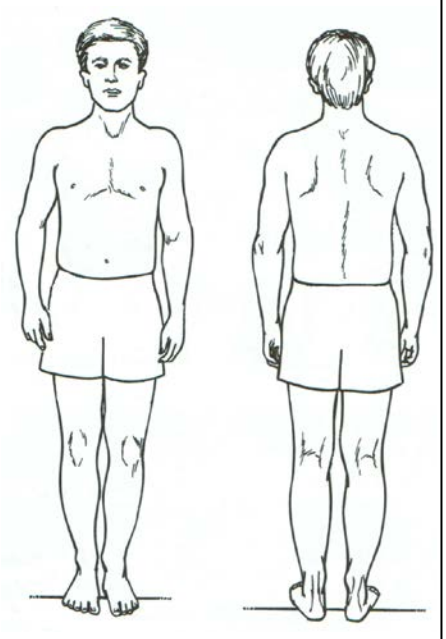
IF REFERED BY FRIEND OR FAMILY, HIS/HER NAME:

HEALTH QUESTIONNAIRE

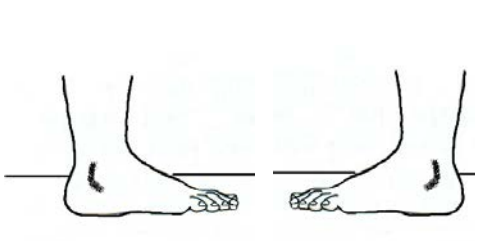
MY FOOT PROBLEMS INVOLVE: ☐ LEFT FOOT ☐ RIGHT FOOT ☐ BOTH FEET

PLEASE MARK AND DESCRIBE ON THE DIAGRAMS WHERE YOU ARE EXPERIENCING PROBLEMS

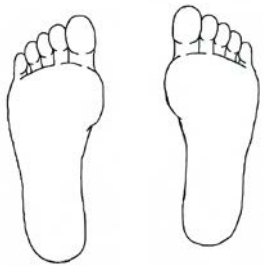
FRONT **BACK**

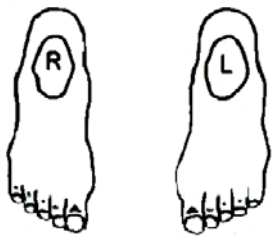


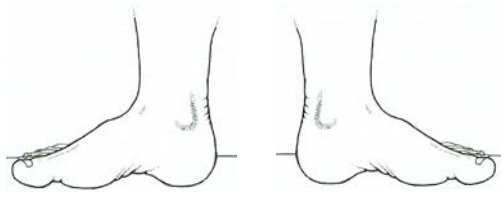
RIGHT **LEFT**



RIGHT **LEFT**







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PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU MAY HAVE NOW OR HAVE HAD IN THE PAST.

Y= YES **N= NO**

GENERAL

Y	N	
		ALLERGIES
		VISION PROBLEMS
		HEARING PROBLEMS
		ASTHMA
		DEPRESSION
		PSORIASIS/ECZEMA
		ARTHRITIS
		OTHER:

FOOT PROBLEMS

Y	N	
		NAIL PROBLEMS
		CALLUS
		CORNS
		WARTS
		NAIL INFECTION
		FLAT ARCHES
		HIGH ARCHES
		BUNIONS
		OTHER:

MUSCLE – JOINT

Y	N	
		FOOT PAIN
		ANKLE PAIN
		KNEE PAIN
		HIP PAIN
		BACK PAIN
		SCIATICA
		NECK PAIN
		FIBROMYALGIA
		OTHER:

CV AND ENDOCRINE

Y	N	
		HIGH BLOOD PRESSURE
		LOW BLOOD PRESSURE
		POOR CIRCULATION
		ULCERS
		SWELLING OF ANKLES
		VARICOSE VEINS
		DIABETES
		THYROID PROBLEMS
		CANCER
		HIV + AIDS
		OTHER:

DO YOU WEAR?

Y	N	
		CUSTOM ORTHOTICS
		INSOLES (OVER THE COUNTER)
		ORTHOPEDIC SHOES
		OTHER:

	WEIGHT
	HEIGHT
	SHOE SIZE

MEDICATIONS PRESENTLY TAKEN

WHICH FOOTWEAR STYLES DO YOU WEAR?

	ATHLETIC/ RUNNING SHOES
	WALKING SHOES
	LACED OXFORD STYLE
	LOW PUMPS/ LOW DRESS (<1.5')
	HIGH HEELS (>1.5")
	COWBOY BOOTS
	SAFETY SHOES/ BOOTS
	SANDALS
	CLOGS
	OTHER:

WHAT DO YOU WEAR AT HOME?

	SLIPPERS
	SOCKS
	SHOES
	BARE FEET
	OTHER:

INFORMED CONSENT TO CHIROPODY TREATMENT

I hereby request and consent to Chiropody treatment, including various modes of physical therapy, on me by the Chiropodist and/or anyone working in the clinic authorized by the Chiropodist.

I have had an opportunity to discuss with the Chiropodist and/or with other clinic/office personnel, the nature and purpose of Chiropody and other procedures. I understand that results are not guaranteed.

I understand and am informed that 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 judgment during the course of the procedure which the Chiropodist feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

TO BE COMPLETED BY THE PATIENT:

DATE: **SIGNATURE OF THE PATIENT/ PARENT/ GUARDIAN**

ACADEMY FOOT & ORTHOTIC CLINICS

www.academyclinics.com **752 Broadview Ave.**
academyclinics@gmail.com **Toronto, ON M4K 2P1**

CHIROPODY FEE SCHEDULE

Initial Visit	**130**
Treatment	**80**
Biomechanical Exam	**120**
Custom Orthotics	**500**
Fungal Nail Laser Treatment	**300**
Laser Wart Removal	**150**
Shockwave Therapy	**150**
Toenail Surgery	**350-600**
Local Anesthesia	**75**
Therapy	
Physical Therapy	**70**
A.R.T – Active Release Therapy	**70**
F.M.T – Foot Mobilization Technique	**70**
Acupuncture	**70**
Compression Stockings	**110-225**
Nail Bracing	**175**

This is to inform our patients that no part of Chiropody services is covered by OHIP, although these services are covered by most Extended Health Insurance Plans, Department of Veteran Affairs (DVA) and Worker's Safety Insurance Board (WSIB).

Please note:

- **The patient is responsible for any deductibles and co-insurance fees**
- **Payment is due when services are rendered**

I understand and agree to the aforementioned terms and I agree to pay for services rendered.

LATE/CANCELLATION POLICY ***Please read and initial at the bottom***

Our Chiropodists are highly sought after and can only see a number of patients per day. As your appointment is reserved specifically for you, please provide **24** hours notice to cancel or reschedule.

Out of respect for the time of our staff and patients, we will be mailing out an invoice to any client who does not show up or cancels with less than **24** hours notice.

If you arrive late for your appointment, we will try to accommodate you, however, your treatment time may be shortened to maintain clinic schedule. Please expect to be billed for the full cost of the original booking.

Initial ____

_____ _____

Signature **Date**

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INSURANCE INFORMATION

Please fill out the following with your insurance information so the clinic can verify your coverage.

- **Does your spouse have extended Health Care Insurance?**

☐YES, complete below:

		SPOUSE'S INSURANCE	
NAME:		**NAME:**	
D.O.B. d/m/y: *Date of birth*		**D.O.B.** d/m/y: *Date of birth*	
INSURACY COMPANY:		**INSURANCY COMPANY:**	
POLICY GROUP #		**POLICY GROUP #**	
CERTIFICATE ID #		**CERTIFICATE ID #**	
EMPLOYER:		**EMPLOYER:**	

FOR OFFICE USE ONLY

COVERAGE FOR:	**% Covered**	**$ Max**	**Per year**	**Per Visit**	**Deductible**
D.Ch. Visits					
Orthotics					
Orthopedic Shoes ☐OTC ☐Custom Made				Notes:	
Compression Socks					

Gradient:
☐15-20mmHg
☐ 20-30mmHg
☐ >40mmHg

Referred By:
☐ MD
☐ D.Ch.
☐ Other

Orthotic and Shoe Submission Requirements:
Referred By: ☐ MD ☐ D.Ch.
☐ P/up date ☐ Paid in full
☐ Lab invoice ☐ Biomechanical Exam
☐ Assignment of benefits ☐ Make/Model of shoe

Date Called:	Rep's Name

Insurance Billing Address: _____
_____