

**Patient Consent for Podiatry Treatment Form Patient Name: DoB:**

**Practice Name: Feet First**

# Patient agreement to Podiatry Treatment

Name :…………...........................................................................

Date of birth :……..................................................................

Address :…………………………………………………………………….

Phone number :……………………………………………………………

**Consent to Podiatry Treatment.**

* Consent to being treated by a Podiatrist
* I understand that I am to be seen/treated by a Podiatrist.
* I confirm that I am aware that Podiatrists may use sharp medical instruments.

## **Appointment Cancellation Policy Agreement:**

Feet First is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

**Please call us on** 07748 371752 **by 2:00 p.m. on the day prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a**Monday**appointment, please call by 2:00 p.m. on**Friday***.***

If prior notification is not given, you will be charged 100% of the fee for the missed appointment.

**Data Consent.**

We collect certain data from you to meet mandatory requirements regarding medical notes. There is a legal requirement to keep medical notes for a period of time after treatment. This can vary in length depending on your age and ability to consent but will be for a minimum of 7 years. Your details will be destroyed after this period.

Please note if you do not consent we will be unable to carry out any assessment or treatment.

There may be occasions where we may want to share information with your General Practitioner.

We also collect data to assist in the administration of our business to provide you with an efficient service. We would like to use your contact details to assist with the administration of your appointments / changes to scheduled appointments and/ or reminders about appointments. To further enhance our service to you, we would like to be able to update you on any information regarding the practice.

We take your privacy seriously and will take all reasonable steps to ensure the protection of your data. Please note that your right to be forgotten cannot override the legal requirement to keep medical notes for the mandatory period. You can request a copy of any data held on you.

If you consent to all of the above please sign, if you are unsure about any of the above information please ask before signing.

Patient Signature (Client’s Parent/Guardian if under 18):

Date:

GP practice:

ALL medical conditions, operations:

Medication:

Allergies:

What would you like help with today: