New Patient Office Policy and Fee Schedule

Chiropody Services are NOT covered by OHIP

Insurance: Chiropody services and products are covered under most extended health insurance plans. Payment for Chiropody services and or products are expected in full after each visit. Details of your insurance coverage is your responsibility. Please contact your insurance provider with questions regarding your coverage. Co-payments and or deductibles with your insurance provider are your responsibility. You are responsible for any unpaid balance for Chiropody services and or products that are unpaid by your insurance provider.

Assignment of Benefits: If you elect to have your insurance provider assign your benefits to Mount Joy Foot Clinic & Orthotic Centre, you certify that you (or any dependents) have coverage with an insurance provider as presented and assign payment directly to Mount Joy Foot Clinic & Orthotic Centre for all services rendered and products dispensed. Any unpaid balances with be processed to the pre-authorized method of payment on file.

Fees: Fees for our products and services are subject to change without prior notice. Please refer to our fee guide for detailed pricing of our products and services.

PATIENT INFORMATION

First Name_____ Last Name _____ DATE OF BIRTH (MM/DD/YYYY) _____ /_____ /_____

Address_____ Apartment # _____ City/Town _____ Postal Code_____

Home Phone # _____ Mobile Phone # _____ E-mail _____

Emergency Contact Name _____ Relationship _____ Emergency Phone # _____

Parent/Guardian Name (if patient is under 16 years of age): _____

HOW DID YOU HEAR ABOUT THE MOUNT JOY FOOT CLINIC & ORTHOTIC CENTRE?

[ ] Family / Friend Name: _____ [ ] Yellow Pages [ ] Doctor Referral; Name: _____

[ ] Google [ ] Yahoo [ ] Yelp [ ] Lakeview Magazine [ ] Other – Please list: _____

PLEASE ANSWER THE FOLLOWING FOOT HEALTH RELATED QUESTIONS

Your primary complaint involves: [ ] Right foot [ ] Left foot [ ] Other Explain: _____

How long have the symptoms been present? [ ] 0 to 8 weeks [ ] 2 to 6 Months [ ] 6 to 12 months [ ] 1 year +

Is your foot related problem getting? [ ] Worse [ ] Better [ ] No change

Have you been treated for any of the following? (Check all that apply)

[ ] Flat feet	[ ] Corn(s) / Callus	[ ] Plantar wart(s)	[ ] Toenail fungus	[ ] Athletes foot
[ ] Heel pain / plantar fasciitis	[ ] Ingrown toenail(s)	[ ] Bunion(s)	[ ] Hammer toe(s)	[ ] Cracked heels / Dry skin
[ ] Arch pain	[ ] Ankle injury / pain	[ ] Knee / Back injury / pain	[ ] Ball of foot injury / pain	[ ] Neuroma

Have you ever worn custom foot orthotics? [ ] Yes [ ] No **What is your current?** Height _____'_____" Weight _____ lbs / Kg, **Shoe Size:** _____

PATIENT MEDICAL HISTORY

Please list your **current medications**: _____

_____

Family doctor name _____ Consent to contact family doctor as part of treatment plan? [ ] Yes [ ] No

Have you been treated for any of the following? (Please mark all that apply)

[ ] Angina / Chest pain	[ ] Anxiety	[ ] Asthma	[ ] Cancer	[ ] Congestive heart failure
[ ] Depression	[ ] Diabetes (Type 1 / Type 2)	[ ] Digestive disorder	[ ] Eczema	[ ] Emphysema
[ ] Epilepsy	[ ] Heart Attack	[ ] Hepatitis	[ ] High blood pressure	[ ] High cholesterol
[ ] HIV / AIDS	[ ] Kidney disease	[ ] Liver disease	[ ] Osteoarthritis	[ ] Poor circulation
[ ] Psoriasis	[ ] Rheumatoid arthritis	[ ] Shortness of breath	[ ] Stroke / CVA	[ ] Thyroid disorder (Hypo / Hyper)
[ ] Urinary trouble	[ ] Other: _____			

Allergies (Please list all known) _____ Are you pregnant / breast feeding? [ ] Yes [ ] No

PATIENT CONSENT AND AUTHORIZATION FOR CHIROPODY TREATMENT

I acknowledge that all the above information is correct. I understand that this information is confidential and will be used for no other purpose than for the Chiropodist(s) clinical record.

I hereby give consent to the examination and treatment by the Chiropodist(s) and or his associate(s) and allow photographs of the treatment area for documentation, monitoring and educational purposes only. I consent the Chiropodist to send my physician or health care professional a report regarding my foot exam and treatment plan only when necessary. I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service and product fees are payable at the time service is provided or products are dispensed.

PATIENT SIGNATURE (Parent / Guardian if under 16) _X_____ **DATE** (MM/DD/YYYY) _____