SK Foot Care Collective
1B - 701 Centennial Dr N, Martensville, SK S0K 0A2, Canada
Phone: 3062619445
Email: skfootcarecollective@gmail.com

Client's Name:
Email:
Phone:
Address:

Consent For Treatment/Photography

Date:

I_____, hereby voluntarily consent to the treatment of care, provided by _____of SK Foot Care Collective, in the Province of SK, Canada.

I have received the following information:

INFORMED CONSENT – PROCEDURE/TREATMENT

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with client. The goal of the assessment process is to determine the best course of treatment for client. Typically, treatment is provided over the course of several weeks or possibly longer.

SK Foot Care Collective does provide basic and advanced foot care.

The following care will involve one or more of the following procedures:

Assessment of Medical History, lower legs, footwear and/or orthotics

Trimming/filing of toenails, reduction of corns, calluses

Trimming of ingrown toenails

Digital photographs of the client's feet

Foot Care health teaching

Application of moisturizer &/or

Application of Onyfix as a means of nail correction treatment

Application of ToeFx as means of correction of fungal nails

Application of toe cushions and spacers and padding as means of prevention and maintainence of foot/toe issues.

Procedure risks include but are not limited to:

skin tears, accidental clipping of skin, (cuticle, hyponichium lateral or proximal nails folds),

cracked nails, splitting nails, or infection.

I give my informed consent to one or all of the above procedures by SK Foot Care Collective that carry professional liability insurance, who uses best practices including the use of one-time use or sterilized instruments, practices within his/her scope of practice and will endeavor to use his/her best judgment to keep the client safety.I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not.

I understand there are risks of the procedures/treatments I seek, as well as those additional risks and complications, benefits, and alternatives.

It is possible for SK Foot Care Collective to share your assessment and treatment documentation with your family doctor or other medical/nursing professionals you work with. I consent that this documentation be shared with other health professionals.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment).

I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with the provider.

If you have questions, you are encouraged and expected to ask them before you sign this form.

I_____, hereby grant permission to SK Foot Care Collective to take and use photographs of my feet and or legs for the purpose of foot care assessment, documentation, educational materials, and promotional purposes.

Duration:
I consent to be photographed before, during, and after the procedure(s) or treatment (s) to be performed if needed, including appropriate portions of my body, for medical, documentation or educational purposes, provided my identity is not revealed by the pictures..

Revocation:
I reserve the right to revoke this consent at any time by contacting SK Foot Care Collective.

By signing this form, I acknowledge and consent to the information contained in it.

Written Name Of Client Receiving Treatment:

Proxy/POA's Name If Legally Responsible For Client Receiving Treatment:

Signature:

(Optional) I Consent That These Images May Be Used For Education/marketing Purposes.:

- ☐ **Yes**
- ☐ **No**