Donna Shewfelt *D.Ch.*
Registered Chiropodist

37 Sandiford Drive, Suite 102, Stouffville, Ontario L4A 3Z2
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Welcome to our clinic!
Chiropody services in Ontario are not covered by OHIP, but are covered by most Third Party Insurance, Extended Health Care Plans & Veterans' Affairs, and/or can be used for income tax health deduction purposes.

GENERAL CHIROPODY FEE SCHEDULE

Initial Visit New Patient Fee $80
Return Visit $60
Return Visit Seniors (65+) $55
Custom Orthotics $500
Includes biomechanical assessment, gait analysis, 3-D casting, 1 pair of orthotics, fitting, review and adjustments within 6 months of dispensing. $380 for 2nd Pair within 6 months.
$250 non-refundable deposit due at time of casting

Nail Surgery:. . . . . $400-$800
Soft Tissue Procedure:. . . . . $200-$600
(cyst removal, wart excision)
SWIFT Microwave Therapy Wart Treatment:. . . $185-$555
3 Treatments
Fungal Nail Testing: $70
Compression Stockings *(20-30mmHg)*: **Knee high: $120**
. . . . . Thigh high: $160
. . . . . Pantyhose: $200

Please note we require 24 hours notification for appointment cancellations.
Should you fail to cancel your appointment within 24 hours you will be charged $37.

Payment in full is required after treatment. Prices may be subject to a yearly increase

CHIROPODY CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the fully qualified and licensed Chiropodists at Stouffville Family Footcare. I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes.

Chiropody services are not covered by OHIP. There is a fee for all Chiropody appointments. Most extended health care benefits cover Chiropody services. It is up to you, the patient to submit to your insurer for reimbursement. Please contact your insurance provider before your appointment to discuss your specific plan coverage for Chiropody treatment and orthotics coverage. Payment is required at the time of the appointment.

In the case of orthotic management, a $250 non-refundable deposit is required at the time of casting. The remainder of the balance is due at the orthotic fitting appointment. Every effort will be made to satisfy the medical issue being addressed, however outcomes are not guaranteed.

I understand that the clinical, psychological and any other information that is gathered during the course of any of my treatment is confidential, but may be shared with my insuring agents, third party players and/or physician(s) upon request. I understand that I may at any time rescind or amend this consent in writing.

By signing below you agree that you have read this agreement and consent to the above fee structure and have had the opportunity to ask questions about its content. This consent will cover all Chiropody assessments and the entire course of your treatment.

Patient Name (please print) **Patient Signature** (or legal guardian) **Date**
By entering your name above, it stands as a legal and binding signature.

Chiropodist Name (please print) **Chiropodist Signature** **Date**

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PATIENT INFORMATION SHEET

First Name	Last Name	Birth Date (yy/mm/dd)

Address: _____

Town: _____

Postal Code: _____

Home Phone: _____

Cell Phone: _____

Email: _____

In Case of Emergency, Please Call:

Name: _____

Phone #: _____

Physician Name: _____

Physician Phone #: _____

Referred by: _____

Veterans Affair Coverage: ☐ Yes ☐ No

#: _____

Occupation: _____

Not Working: ☐ Home ☐ Retired ☐ Disability ☐ Student

% of typical day standing / on feet: _____ %

Sports & Activities:

Physical Attributes:

Height: _____ (ft/in) Weight: _____ (lbs)

Shoe Size: _____

Recent weight gain: ☐ Yes ☐ No

Past pregnancies: _____

Currently pregnant: ☐ Yes ☐ No

Past Surgeries and or Hospitalizations: (Indicate year)

Medication/Drugs: ☐ None

Please list all current prescriptions and over the counter medications:

Do you take Aspirin or other Blood Thinners?

☐ Yes ☐ No

Cigarette Use: ☐ Yes ☐ No ☐ Previous use

years Tobacco use: _____

☐ less than 1 pack/day

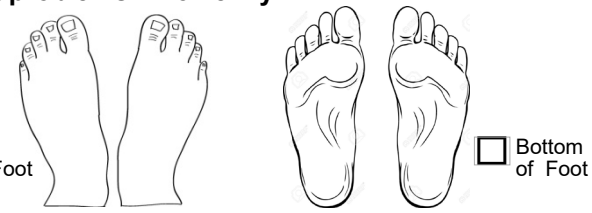
☐ 1 pack/day

☐ more than 1 pack/day

Alcohol Use: ☐ Yes ☐ No ☐ Previous use

☐ 1-2/week ☐ >3/week ☐ 1-2/day ☐ >3/day

My foot problems involve my :



☐ Top of Foot ☐ Bottom of Foot

Briefly describe your current foot problems:

I have seen a Chiropodist/Podiatrist before: ☐ Yes ☐ No

I have worn custom orthotics before: ☐ Yes ☐ No

Allergies:

☐ No Known Allergies

☐ Yes (Check boxes below):

Medication

☐ Aspirin
☐ Codeine
☐ Ibuprofen/NSAIDs
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa Drugs
☐ Steroids
☐ Demerol

Chemical

☐ Adhesives/Tapes
☐ Elastoplasts
☐ Latex
☐ Metals
☐ Other:

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HEALTH HISTORY

Do you have, or have you ever been diagnosed with any of the following?

Please check all that apply:

☐ **Diabetes:**	☐ Coronary Artery Disease	☐ Rash/Skin problems
☐ Type 1	☐ Heart Arrhythmias	☐ Stomach Ulcer
☐ Type 2	☐ Pace maker	☐ Crohn's/Colitis
☐ Borderline	☐ Cancer	☐ Diverticulitis
☐ Gestational	☐ High Cholesterol	☐ Multiple Sclerosis
☐ **Arthritis:**	☐ Varicose veins	☐ Muscular Dystrophy
☐ Osteo	☐ Bleeding disorders	☐ Polio
☐ Rheumatoid	☐ Anemia	☐ Rheumatic/Scarlet Fever
☐ Psoriatic	☐ Blood Clots	☐ Anxiety
☐ Heart Attack	☐ Thyroid disease	☐ Depression
Year: _____	☐ Kidney disease	☐ Claustrophobia
☐ Stroke	☐ Liver disease	☐ Schizophrenia
Year: _____	☐ Osteoporosis	☐ Bipolar
☐ Seizures/Epilepsy	☐ Gout	☐ Migraines
☐ Angina/ Chest Pain	☐ Asthma	☐ Vision Loss/Blindness
☐ High blood pressure	☐ Emphysema	☐ HIV/AIDS
☐ Low blood pressure	☐ Tuberculosis	☐ Hepatitis A/B/C
☐ COPD	☐ Psoriasis	☐ Fibromyalgia
☐ Congestive heart failure	☐ Eczema	

Other: _____

_____