THE PODIATRY ASSOCIATES INC.
PROFESSIONAL FOOT CARE CLINIC

Patient Intake Form

New Patient **Return Patient**

Name: _____
First Middle Initial Last

Home Tel: _____ Cell Phone:_____

Email: _____

How would you like us to remind you of your appointment time? _____
(Phone, text or email?)

Birthdate: _____/_____/_____ Pronouns: _____
Month Day Year

Address:_____
Apt/Street City Province Postal Code

Occupation:_____

Shoe Size: _____ Height: _____ Weight: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____Tel:_____

Whom may we thank for referring you:_____

Family Dr: _____Office Location: _____

MCP #: _____

Insurance Provider: _____

Reason for today's visit:_____

Phone: 739-3338Fax: 739-4214Web: www.doyourfeethurt.ca
1 Anderson Avenue St. Johns NL A1B 3E1

MEDICAL HISTORY

Please indicate if you have or had any of the following:

__Arthritis	__Cancer	__Heart Disease	__Kidney Problems
__Pacemaker	__Stomach Ulcers	__Rheumatic Fever	__Liver Problems
__Asthma	__Circulatory Problems	__Hepatitis	__Autoimmune Disease
__Back Problems	__Diabetes	__HIV/AIDS	
__Bleeding Disorder	__Epilepsy	__High Blood Pressure	

Other: _____

Allergies: _____

Fee Schedule-2026

Initial Visit $75.00 Return Visit $65.00 Orthotics $485.00
Nail Surgery $295.00 per toe

Please note:

- The Podiatry Associates Inc. is a private paramedical service. Our fees for the service are **NOT** covered by M.C.P. but are fully or partially covered by most personal extended health care plans. We do **NOT** provide any direct billing to personal extended health care plans. If you have any questions regarding the coverage of Podiatry services, you should contact your health benefit plan provider.
- Podiatry services may be covered by WHSCC or DVA, however, **pre-approval** is required prior to appointment. If the request for approval is not complete before the initial visit or the claim is denied, the cost of the service is the responsibility of the patient.
- Payment in full is required at the time of treatment. In cases where custom foot orthotics are prescribed, full payment is due at the time of casting.
- We will gladly adjust custom foot orthotics during the initial three months of wear to ensure the devices are achieving their intended functions. There are no refunds on custom devices.
- Most patients obtain good results from nail surgery however adverse outcomes can occur as any surgery carries an element of risk. While all care is taken to recognise and minimize risk, complications may include but not limited to; post-operative infections which may require oral or intravenous antibiotics, regrowth / recurrence, delay or failure of soft tissues to heal, delayed return to footwear, epidermal cysts requiring removal. The risk of complications will increase if post-operative instructions and advice are not followed. This includes advice on the cessation of smoking. Further nail surgery or treatment may be required if an adverse outcome occurs. I acknowledge that I have been advised of the risks associated with this procedure, the requirement to follow postoperative instructions and the possible post-surgery complications. I have also been advised of the approximate cost including out of pocket expenses for this procedure.
- Any patient displaying inappropriate behavior, using aggressive or offensive language or failing to comply with a prescribed treatment plan may be dismissed from the clinic. If indicated,

authorities will be contacted immediately.

Late Cancelled/Missed Appointment Policy

- Due to the high volume of demand for medical services, we require 24-hour notice for all cancelled or rescheduled appointments. A $30.00 fee will apply for insufficient notice if the appointment time cannot be filled and must be paid before any appointment is rebooked. Latecomers may be required to re-schedule for the same or a later date and appropriate charges for the late or missed appointment may apply. Extenuating circumstances will be taken into consideration.

- **Please note:** you are responsible for payment of any **No Show fee** as 3rd party insurance companies will not honour this charge.

I understand and acknowledge the above policies,

Signature: _____ Date: _____

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