



CONSENT FORM FOR ONYFIX TREATMENT

Under the GDPR (General Data Protection Regulations) we are legally required to gain your consent to collect and use personal information about you. Please read the following carefully and sign the declarations if you consent to us collecting this information.

Consent to Clinical Photography

- I consent for photographs to be taken for clinical purposes and they will form part of my records. They may also be used for training purposes or research. I will not be identified personally, if the pictures are shared as above.

Signed: _____

Date: __/__/__

Consent to Clinical Examination and Onyfix Treatment by a Podiatrist or Foot Health Practitioner

Description of procedure (to be completed by the Clinician)

Onyfix treatment carried out:

Risks:

- Treatment may not work
- Discomfort on preparing the nail for application

Benefits:

- Resolution of the problem (partial or complete)
- It has been explained to me that it will take several months to complete this treatment and that during this time, I may need to have another Onyfix band or bands applied to complete the treatment and that each one of these carries a separate charge.

Alternative options discussed:

(conservative management, other treatments no treatment at all)

YES

NO

I voluntarily consent for ONYFIX treatment by a Podiatrist or Foot Health Practitioner. The clinician treating me is fully trained and certified in this treatment. I understand that because of human variance it is not possible to guarantee the outcome of any medical care or service. As with all forms of treatment there are risks and benefits, as discussed. I agree to ask questions to clarify treatment should I not understand. I confirm that the details I have provided are true and correct to the best of my knowledge.

Signed: _____

Date: __/__/__

Privacy Policy

We need to collect some personal and medical information from you. This information may be used for:

- The administrative running of the practice.
 - Billing, either directly or through a third party such as your insurance providers.
 - Use within the organisation, when passing information to other clinical staff for your ongoing treatment and care.
 - Disclosure of treatment and medical information to your other clinical treatment providers.
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- I understand that it is my choice what information I provide but that withholding or falsifying information might be detrimental to my treatment.
 - I consent to allow the clinic to collect further information related to my foot health care treatment, from other sources as necessary, including x-ray reports, medical reports etc.

Signed: _____

Date: __/__/__