Sarasota Foot and Ankle Center
Drs. Dawn Chiu & Arthur D. Clode, D.P.M.
3428 17th Street
Sarasota, FL 34235

Tel: 941-366-4888
Fax: 941-366-4889

CONSENT FOR PODIATRIC TREATMENT

Patient Name: _____

Facility: _____

I, _____ (patient/POA) authorize Drs. Dawn Chiu/ Arthur Clode, DPMs to perform any necessary podiatric medical care upon the patient named above. This includes and is not limited to evaluation and management of nail care, callus care, wound care, foot/ankle pains, foot health assessment, etc.

I acknowledge that podiatric medical care carries potential risks and benefits, and the possible complications of any treatment will be explained to me beforehand as well as the possible risks and benefits of alternative podiatric medical treatment can be discussed with me at any time.

I acknowledge that if any invasive procedure needs to be performed, it will be thoroughly explained to me with another objective medical professional i.e. nurse, nurse's aide, patient care advocate, etc. be present.

I acknowledge that I may refuse treatment from Drs. Chiu/Dr. Clode or end her/his involvement in my podiatric care at any time. I understand that I may use any other podiatrist exclusively or as a second opinion without fear of retaliation from Dr. Chiu/Dr. Clode.

I acknowledge that I will be financially responsible for all charges not paid by my insurance including deductible amount, co-insurance, or any unpaid balance. I request that payment of authorized benefits be paid on my behalf and assign those benefits to the practice listed above.

_____ _____

Patient / POA signature Date

POA NAME: _____

TEL NO.: _____

BILLING ADDRESS: