PATIENT TREATMENT PLAN

Patient Name:____

Practitioner:_______________________________Therapist:____________________________________

Date:____

The Patient named is in agreement with the following treatment/device/services plan outlined below:

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Patient further understands that you are receiving a custom made device/alteration to device/or shoe modification that is not returnable or exchangeable. The device you receive is under warranty for a period of ninety (90) days and has free lifetime adjustments. Decisions regarding shoe modifications and heel lift heights are made in part with all members of your rehabilitation team. We are a dispensing agency and want to help you and your rehabilitation team to achieve the best outcome of your therapy care. The fit of any item is largely subjective. We rely on the patient to let us know if the item we are dispensing is a proper fit. The device you receive may fall under same or similar insurance ruling per calendar year. You understand that you are financially responsible for further alterations/ repairs/ or modifications made to the device not covered by warranty or insurance.

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Patient Signature Date