Custom Foot Orthotics

Insurance Requirements:

*Most **extended health insurance** plans cover "Custom Foot Orthotics". Please **check your benefits carefully** for the details of your coverage and insurance requirements for **"Custom Made (moulded) Orthotics"** and **complete the following checklist** prior to your appointment, to ensure that your insurance requirements are being met.*

I. Who is your health benefits insurance provider? ________________________________

II. Are **"Custom Foot Orthotics"** covered by your insurance plan? ☐ Yes ☐No

III. What are the **coverage limits** of your plan for Orthotics? $___________

IV. Do you require a **"Prescription"** for your Orthotics to be covered? ☐ Yes ☐No

If yes, who is able to **Prescribe** your Orthotics?
☐Physician (MD) ☐Podiatrist ☐Chiropodist ☐Chiropractor ☐No restrictions

V. Who is able to **Dispense** your Orthotics?
☐Podiatrist ☐Chiropodist ☐Pedorthist ☐Orthotist ☐Chiropractor ☐No restrictions

If your Orthotics are able to be dispensed by a "Chiropodist", do you have coverage for **"Chiropody"** services? ☐ Yes ☐No

Fees & Payment Policies:

Fees: Custom Made (moulded) Orthotics = **$400.00** per pair (Standard shell materials)

Forms of Payment: We accept **cheque**, **Visa**, **Mastercard**, and **debit**

Refunds: Orthotic purchases are **100% non-refundable** once your order has been placed to the lab for manufacturing.

Expectations: Payment for your orthotics is **due in full at the time your order is placed**. This will allow you to submit your **paid receipt** to your insurance company for claim processing.

You will be provided with the following items:

☑Paid Reciept
☑Gait Analysis & Biomechanical Assessment Report
☑Insurance Dispensing Letter - inclusive

- Summary of clinical findings & Diagnosis
- Description of assessment techniques & casting method
- Description of the manufacturing process and materials
- Laboratory credentials and accreditation

I,________________________________ have made reasonable inquiry of the above information and certify that, to the best of my knowledge, the information I have provided is correct.

Patient Signature: ________________________________ *Date:*_______________