

EMP INITIALS: _____

ORTHOTIC RE-ORDER FORM

DATE: _____ PATIENT NAME: _____ DOB: _____

Mailing address: _____

City: _____ State: _____ Zip _____ Phone _____

DATE LAST SEEN: _____ CURRENT INSURANCE: _____

(please circle)

I am dropping off my **orthotics/orthotic molds/ my molds are digital** and would like the following:

- a second pair of orthotics the same as the 1st pair.
 - a second pair of orthotics different from the 1st pair (indicate difference) _____
 - an adjustment to my current orthotics (indicate request) _____
- (Additional charges may be applicable if beyond 6 months from date of dispense)**
- Top Covers/minor repairs added/made to my orthotics *****\$62.00 *** is our prompt pay fee (without billing insurance) & is due at drop off*** \$82.00*** is our fee for both patients & insurance if you require we bill your insurance & payment is made after drop off date*****
 - other: _____

YOU WILL RECEIVE A /TEXT/EMAIL WHEN YOUR ORTHOTICS ARE IN

Patient/ Representative Signature for drop off

Date

I have requested to **pick-up** orthotics for myself/above patient (please circle) because it is not necessary to be fitted to insure these orthotics fit properly since *it is a Second pair / Remake / Adjustment/ Other* _____

(Please Circle)

- Orthotics dispensed Date: _____ To: _____ (initial) By A & F Employee: _____
- Orthotic check follow-up appointment date: _____
- I decline a follow up appointment with the doctor at this time **Comments:** _____
- Fee slip completed **A & F Employee:** _____
- Patient balance owed** _____ *yes* \$ _____ Amount Paid: \$ _____
_____ *no* _____ N/C
- Insurance pending:** _____ *yes* _____ *no*

Patient Name (Please Print)

SIGNATURE (for pick up)

Date

(UNDER 18) Patient Representative (Please Print)

SIGNATURE

Date