ANKLE & FOOT CLINIC'S NORTHWEST
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EVERETT WA 98201
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ALPINE FOOT & ANKLE
17432 SMOKEY POINT BLVD STE 103
ARLINGTON, WA 98233
(PH) 360-653-2326 (FAX) 360-658-8944

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