933 N Topeka
Wichita, KS 67214
316-269-3338 office
316-264-5516 fax

613 N. Main St.
El Dorado, KS 67042
316-320-3338 office
316-322-8192 fax

Central Kansas Podiatry Associates
CUSTOM MADE FOOT ORTHOTIC WAIVER

The physician has prescribed for you, custom manufactured prescription functional or accommodative orthotic foot devices which are medically necessary for the treatment of several types of foot problems. I am aware that while there is no guarantee on the outcome of treatment with orthotics, I do understand that my physician will make every reasonable attempt to correct my foot problems using the afore mentioned appliances.

The difference between a basic standard appliance which can be purchased over the counter and the PRESCRIPTION orthotic being made for you is the level of correction and prognosis for your foot problem. The orthotic is custom designed to your foot and its size and shape.

Some insurance companies may provide coverage for medically necessary foot orthotic devices; however there are many insurance companies that do not cover this type of care. These include but are not limited to Medicare and Blue Cross/Blue Shield of Kansas. Your insurance carrier may pay a percentage of the entire cost of the medically necessary prescription orthotic device. If you wish, we can submit these charges for you with the exception of Medicare and Blue Cross/Blue Shield. Preferred Health Care requires charges to be submitted individually. In this case, the included services do not apply. Contact billing for details. Scheduled payments must be made on your account regardless of insurance billing status.

****

I am aware that I am fully and financially responsible for the cost of the orthotics being made for me. This waiver indicates **my approval** for such services. I am aware that all or a percentage of the total cost of the orthotics may not be covered by my insurance carrier and will be fully and financially responsible to pay the balance of the amount that the insurance carrier did not cover. This could possibly include my yearly deductible. I also understand that if the insurance company deems the custom orthotics as not medically necessary or if custom orthotics are a non- covered service, I am fully financially responsible for the entire amount of the charge. If the insurance company pays directly to the patient, full payment is due immediately from the patient.

I understand that the services included in the cost of the orthotics are **INITIAL CASTING, THE ORTHOTIC DEVICES, AND TWO FOLLOW UP VISITS ON THE APPLIANCES**. The factory that manufactures the orthotic devices provides a separate warranty on the orthotics and the cover. This will vary depending upon which factory is best suited to your specific orthotics needs. Excessive damage, intentional or accidental voids the manufactures warranty. The cost of the orthotics is **NON-REFUNDABLE** and the orthotic **MAY NOT BE RETURNED** for a refund because the orthotics are a custom made item._____(patient initial) I am also aware that the cost of the orthotics **DOES NOT INCLUDE**: special casting fees, cast mailing fees, strapping, office visits, repair costs (unless defective or under warranty), whirlpools, injections, x-rays or ultrasound therapy. These treatments or services are at an additional cost billed to me unless covered by insurance. These costs are billed at the time of service and cannot be predetermined.

I hereby authorize the Doctor to cast and order custom orthotic foot devices and to bill me for any fees not approved or fully covered by my insurance company. **Self pay patients: a $175 deposit is required to initiate the ordering process and is non-refundable due to orthotics being a custom made item.** I will make a deposit of **$175.00** on the devices before the orthotics will be ordered from the laboratory. Once the orthotic laboratory begins the manufacturing process, the full amount of $**350.00 is due and payable.** I also understand that the balance of $**175.00** ($350.00 minus the $175.00 deposit) is due and payable at the time that the orthotics are dispensed to me. If full payment cannot be made, our BILLING DEPARTMENT can make arrangements on an individual basis for a special payment plan.

Signature of Patient _____Date_____

Witness _____Date_____

*copy rc'd*_____/_____ Chart #_____ patient
initials staff initials Insurance_____ self pay_____