

## Central Kansas Podiatry Associates

Benjamin W. Weaver, DPM FACFAOM and Paul Bassi, DPM

933 N Topeka  
Wichita Ks, 67214  
Phone #'s 316-269-3338  
Fax: 316-264-5516

613 N. Main  
El Dorado Ks, 67042  
316-320-3338  
316-322-8192

### BREAK-IN SHOE INSTRUCTIONS

Congratulations on receiving your new shoes. In accordance with your insurance regulations, they have been selected from our inventory, from another company or have been fabricated to provide you with optimum comfort and protection. The shoes were chosen to best accommodate you, the patient, your anatomy and needs as a high risk Diabetic patient. There is a certification from your primary care physician who manages your diabetic care on file. In order to receive the greatest benefit from this footwear, please follow our recommended guidelines.

People with decreased feeling in their feet may have a false sense of security as to how much at risk their feet actually are. With that in mind and in order to best avoid any serious irritation or wound, please adhere to the following break-in schedule

\_\_\_\_\_ Day One – please wear the shoes for one hour and check your feet

\_\_\_\_\_ Day two – Please wear the shoes for two hours checking one hour in to make sure no irritation has occurred

\_\_\_\_\_ Day three – Please wear shoes for three hours, again checking one and a half hours \_\_\_\_\_ in for any irritation

\_\_\_\_\_ Day four – Please wear shoes for four hours, checking two hours for any irritation

\_\_\_\_\_ Day five – Please wear shoe for a full eight hour day checking during lunch that there are no irritations

\_\_\_\_\_ Next two weeks – for the following weeks wear shoes for the entire day, removing both shoes and socks periodically to examine your feet and device(s). Look for anything that looks different or out of the ordinary that may result in injury. This included swelling, redness, calluses, cuts, scratches, blisters, or hot spots. Please call our office immediately if any of the above items are noticed. Please do not make any adjustments yourself.

\_\_\_\_\_ **Your Diabetic shoes and insoles should never be worn without socks.**

\_\_\_\_\_ For all Therapeutic and Diabetic shoes, please perform the break-in period in your home, on carpet. Once you have verified that the shoes feel good and do not cause any rubbing of your skin, you may wear them outside. If you have any redness, issues, or concerns, please stop wearing the shoes immediately and call our office.

Patient Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

# Central Kansas Podiatry Associates

Benjamin W. Weaver, DPM FACFAOM and Paul Bassi, DPM

933 N Topeka  
Wichita Ks, 67214  
Phone #'s 316-269-3338  
Fax: 316-264-5516

613 N. Main  
El Dorado Ks, 67042  
316-320-3338  
316-322-8192

## Follow-up

You should have regularly scheduled visits with our office. Please direct any questions about the item(s) received today to this office. Billing questions may be directed to your Medicare Carrier or our Billing department. Every four months get rid of the inserts in your shoes and replace them with a new pair. In one year please schedule a return visit so we may evaluate and re-order another new pair of shoes with inserts.

## Return Policy

Shoes that are unsuitable may be returned within four weeks of dispensing. The shoes must be in good condition, i.e., no scuffmarks, outside dirt or obvious wear on the soles. We strongly urge you to wear your new shoes in your home for the first week. Substandard shoes may also be returned as all warranties, expressed and implied under applicable State Law will be honored.

The shoes were dispensed by qualified personnel of Central Kansas Podiatry. Written instructions and warrantee information was given along with a Durable Medical Equipment Supplier Guidelines. I certify that I have received the item(s) marked below in good condition. The Doctor/Staff has explained, in detail, the proper use and care of this device(s) and has fit it to me. The Doctor/Staff has asked me to call the office if I encounter any problems with the device(s) or if I have any questions. I have been informed of the Medicare DMEPOS Supplier Standards.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Description: \_\_\_\_\_ Size: \_\_\_\_\_ Width: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Original: To Patient      Copy: To Patient File

---

In Office Notes

---

---