

Natural Elements
Health Center, Inc.
Christine Schlenker, D.C.

Disclosure for Custom Orthotics

Patient Name:_____

I understand that I am being cast for Sole Supports Custom Orthotic devices by Dr. Christine Schlenker. The cost of these orthotic devices will be **\$300.00**, which may or may not be covered by my insurance. This clinic will file my insurance for me with a letter of medical necessity, but this does not guarantee that my insurance will cover the orthotics. The amount paid by the insurance company will be reimbursed to me. **Orthotics are not covered by Medicare or Medicaid.** This clinic will make every effort to make these orthotics work for me, but **the Sole Supports Custom Orthotic Devices are not returnable for a refund or credit.** Because of this, all necessary adjustments needed to make the orthotics work for you, will be done free of charge within the clinic and by Dr. Schlenker.

Because they take 1 ½ weeks to 2 weeks to arrive, and the clinic is billed before they arrive, we request a deposit.

***Deposit made today: \$_____

I agree to pay the remainder of \$_____ at the time the orthotics are given to me.

I (have / have not) chosen to have the custom foot orthotics rush ordered for an additional fee of \$35.00.

By signing my name below, I have agreed to the terms and conditions listed above. I understand that I will be financially responsible for all or a portion of the cost that is not covered by insurance.

Patient Signature:_____Date:___/___/_____

Witness:_____