



# ANKLE & FOOT of Edmonds

A division of Edmonds Orthopedic Center & Proliance Surgeons

D.J. Wardle, DPM      Eric Powell, DPM      Joanne Gormley, DPM      Rex Nilson, DPM  
7320 216<sup>th</sup> Street SW, Suite 320B   Edmonds, WA 98026   Phone: 425.775.6996   Fax: 425.670.8905

## ORTHOTIC REQUEST FORM

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Circle your Doctor's Name:

D.J. Wardle, D.P.M.      Rex Nilson, D.P.M.      Eric Powell, D.P.M.      Joanne Gormley, D.P.M.

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Weight: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Insurance: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

### FOR OFFICE USE ONLY

Orthotic Request \_\_\_\_\_

Insurance Benefit  
Check \_\_\_\_\_



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## ORTHOTIC COVERAGE

Orthotics are custom molded inserts intended to correct an abnormal or irregular walking pattern. Orthotics are not truly or solely "arch supports". They perform functions that make standing, walking, and running more comfortable and efficient by altering slightly the angles at which the foot strikes a walking or running surface.

Once your doctor has recommended orthotics for you, he or she will give you the information needed for you to call your insurance company to verify your benefits. Insurance coverage varies from insurance to insurance and plan to plan.

As a courtesy to you we will bill your insurance company for the orthotics. You need to understand that all fees are your responsibility. Any amount that is not covered by your insurance company will be considered your responsibility.

Some insurance companies do not offer orthotic coverage. For patients with no orthotic coverage, a payment plan is available. For information about payment plans, please talk to one of our front office staff.

### FOR MEDICARE PATIENTS

Medicare does not cover orthotics; therefore we do not bill them. Medicare patients need to pay for their orthotics in full at time of pick up; unless other payment arrangements have been made.

If for some reason your doctor authorizes a return, a refund will be given. The amount refunded will be the total amount that the patient paid for the orthotic appliance minus the lab-processing fee. The financial coordinator will verify the amount paid.

We thank you for letting us be of service to you.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
DOB