InStep Custom Footcare Services
PATIENT INFORMATION
For Office Use Only

PATIENT INFORMATION (if Patient is a minor, please also complete line 2):

Name:____

Parent / Guardian: ____

Address:____

City, State, Zip:____

Home Phone:(   )_______-______________ Other Phone:(   )________-_____________

e-mail address: ____
May InStep contact you for reasons other than appointment confirmation? [Y] [N]

REFERRING PHYSICIAN INFORMATION:

Name of your referring physician / specialty:____

Please tell us where your pain is located: ____

FINANCIAL DISCLOSURE / RELEASE OF INFORMATION

InStep does not directly bill third party insurance for products and services provided by our Custom Footcare Services department. Upon request, one of our Certified Pedorthists would be happy to provide you with the insurance billing code for your prescribed item.

I have been informed at this time that my pedorthic device, which has been prescribed by my physician, may not be covered by any insurance. I understand that I am responsible for filing any claim with my insurance company. Payment is due at the time of service by InStep Custom Footcare Services, unless other arrangements have previously been made.

I understand that prescription pedorthic devices including custom orthoses, OTC orthoses and shoe modifications are not returnable or refundable.

I give my permission for InStep to discuss or release information regarding my diagnosis and treatment with my physician, their staff and other allied health professionals engaged directly in my treatment or my insurance company to assist with processing a personal claim.

I verify the accuracy of the above information.

________________________________ ________________
Patient (or Authorized) Signature Date