PATIENT AGREEMENT WITH WARREN PODIATRY

Medicare or my insurance company **does not pay** for item chosen below that I am purchasing today. I understand that all items are non-refundable.

_____ Orthotics – Custom molded L3020

_____ Orthotic Recovering

_____ Over the counter Orthotics - Purestrides

_____ Diabetic Shoes & Inserts*

_____ Compression stockings

_____ Other supplies:_____

* I understand that there is a **$25 non-refundable** fee for returning shoes/inserts.

I have been notified by my physician's office that Medicare Part B, Blue Care Network or my insurance company does not cover the services I received today. I have read and understand the above statement. I accept liability for those services not covered by Medicare Part B, Blue Care Network or my insurance company.

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT NAME (PRINTED)_____