Patient Name/ID _____

PAYMENT AND REFUND POLICIES

Thank you for choosing Streamline Orthotics and Prosthetics. We are committed to providing you with the best available care. To make sure that all your needs are met, our billing department is available to discuss any questions you may have regarding your co-insurance and this policy with you.

Streamline Orthotics and Prosthetics, LLC will provide your device based on the prescription from your physician and will make every effort to make sure the device fits comfortably, and you are satisfied prior to taking receipt of the device. Items provided are non-returnable and non-refundable once you have taken receipt of the device. However, if you have any concerns about the integrity or fit of the device, please contact Streamline Orthotics and Prosthetics, LLC immediately so that we can assist you.

All custom or special-order devices require payment in full prior to the device being fabricated. Prefabricated devices that are in-stock, full payment is due at fitting. If it is determined that your insurance does not cover all or part of your device, payment is still required in full prior to ordering or fabricating the device, therefore you may be asked to sign an ABN (advanced beneficiary notice) or insurance waiver.

Custom made, or customized items that are not picked up for delivery:
Because your physician has prescribed a device that will be made custom to your specific needs, these devices are not refundable once the process has started. If you fail to come to your delivery appointment to be fitted and pick up your device our office will contact you and attempt to reschedule your appointment. If your device is not picked up within 3 months from the initial evaluation or date of measure, you or your insurance will be billed for that item.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

_____ _____

Signature of Patient or Personal Representative *Date*

_____ _____

Printed Name of Patient or Personal Representative *Relationship to Patient*