

Progressive Step Personal File

Date: _____

Phone: Home () _____

Patient's Name: _____

Work () _____

Address: _____

Cell () _____

City: _____

E-mail: _____

Postal Code: _____

Height: _____ Ft Weight: _____ LBS

Shoe Size: _____

Occupation: _____

Born: Day ___ Mo ___ YR ___

Parent/Guardian (if under 19)

Family Doctor: _____

Name: _____

Referring Professional: _____

Phone: _____

Who May We Thank for your Referral? (Please circle one) another client doctor radio print web

In order for us to give you the appropriate documentation, please circle if you have an extended health plan: NO YES: (if yes, which provider) _____

***If you have circled YES and decide to go ahead with orthotics, please don't send anything to your extended healthcare providers until your final appointment, as we will be giving you an entire package with all the information that they require, as it pertains to your visit with us. **If extended health package is lost or misplaced, we will replace it for a \$20.00 charge.**

*If any of the following pertains to you: NIHB RCMP DVA ICBC WCB MINISTRY

IMPORTANT INFORMATION

Orthotic prices vary to match the individual personal needs. Typically, orthotic fees range from \$450.00-\$500.00. This price includes fabrication of the orthotics, fitting of the orthotics and any adjustments, if required. There is \$75.00 fee for the biomechanical evaluation and assessment.

We are committed to providing the best support for every patient. If proceeding with orthotics, due to the custom nature of the work, a non-refundable deposit is required. Please appreciate the human body is very dynamic and it is difficult to guarantee outcomes; as such there are no refunds, exchanges or credits for custom products/services. If you have any questions please discuss them with your Podiatrist. *Orthotics will **NOT** be dispensed without a referral from a physician. **Orthotics not picked up after **90 days** will no longer be held.

We cannot share your information. Your file is private and confidential and only with your consent can we share your information regarding your file with your Doctor.

I have read the above and consent to having Progressive Step Orthotics & Bracing provide my referring professional with a copy of my Biomechanical Assessment.

Signature: _____ Print-Name _____

