Informed Consent for Chiropractic Examination and Foot Orthotic Therapy

Your chiropractor has prescribed medical devices for you called custom foot orthotics. Orthotics can be an integral part of patient care by health care providers for the management of pedal pathologies and musculoskeletal symptomatology, and to alleviate pain and discomfort from abnormal foot function. Abnormal foot function may affect a patient's kinetic chain, including legs, knees, hips and spine.

Orthotics are designed based upon the degree of patient abnormal foot function, patient activity level, patient physical stature and the type of footwear in which the orthotics are worn. Custom orthotics are foot inserts placed inside footwear.

Your chiropractor will assess your foot function in order to determine if you require foot orthotics and if you do, what type of orthotic will benefit you most.

Many patients experience pain reduction and increased comfort when wearing custom foot orthotics. A small percentage of patients experience discomfort and /or pain when breaking in their orthotics and an even smaller percentage of patients experience significant enough pain that they cannot wear their orthotics at all.

Consent

I have read the information above and hereby request and consent to the performance of the assessment of my foot function and the prescription of custom foot orthotics by _____.

I acknowledge that I have had the opportunity to discuss the nature, purpose, benefits and risks of custom foot orthotics with my chiropractor.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment with custom orthotics. These include but are not limited to foot pain, leg pain, back or neck pain.

I have read the above consent and I have had the opportunity to ask questions about its content and by signing below I agree to the above named treatment/procedure. I intend this consent form to cover the entire course of treatment for present and future condition(s) for which I seek foot orthotic treatment.

I understand that orthotics are non-refundable and not returnable for account credit, as they are custom made for my feet only.

I will be contacted by the office once my orthotic devices have arrived and are ready for pick up.
TO BE COMPLETED BY THE PATIENT (or by Parent or Guardian)

_____ _____
Patient Name Signature of Patient

_____ _____
Date Signed Witness Signature

Fees

Custom Orthotics	**Including Biomechanical Evaluation and Exam Casting, and /or Proprietary Gait Scan and Custom Orthotic Inserts**	**$400**

Disclosure for Custom Foot Orthotics

I understand that I am being casted for Orthotic devices by_____.

The cost of these devices will be **$_____**, which may or may not be covered by my insurance company. Mountain Chiropractic will issue me a receipt to submit to my insurance to cover my orthotics. The amount paid by the insurance company will be reimbursed to me.

The clinic will make every effort to make these orthotics work for me. All adjustments are free but **the orthotics are not returnable for refund or credit.**

Signed_____ Date_____

Witness_____ Date_____