



## **Sales Agreement/Instructions**

**PT NAME** \_\_\_\_\_

### **Shoe Certification**

I understand that Medicare, Medicaid, and Commercial Insurances will only cover one pair of Diabetic Shoes each calendar year. **I have not received diabetic shoes from any other Medicare or Insurance Supplier this year, nor will I accept them from any other company at another time this year.** I also understand that if I request or accept more than one pair in a calendar year, I will be held liable for the cost of the second order, including the inserts.

**Initials** \_\_\_\_\_

### **Shoe/Insert Break in Schedule**

I acknowledge receiving instructions and agree to follow the Shoe Break-in schedule listed below. I understand that it is recommended that I wear socks while wearing shoes and check my feet 2-3 times per day. If I see anything that looks different than normal or out of the ordinary that may result in scratches, blisters, cuts, etc..., I will stop using the shoes and inserts and discontinue use immediately. I will not hold the Diabetic Shoe Supplier, Company or Fitter liable in any way whatsoever for any personal injury or property damage that the shoes, inserts or ankle gauntlets may cause.

**Initials** \_\_\_\_\_

### **Shoe/Insert Wearing Time**

Day 1-3	1 Hour each AM & PM
Day 4-6	2 Hours each AM & PM
Day 7-9	3 Hours each AM & PM
Day 10-12	4 Hours each AM & PM

### **Inserts**

**Rotate the pairs of inserts as often as you think about it to ensure even wear of the insert.**

I acknowledge receiving the above instructions and agree to follow the schedule listed to change the inserts in my Therapeutic Shoes:

**Initials** \_\_\_\_\_

### **Return Policy and Equipment Warranty/Complaint Protocol:**

IF YOU ARE UNHAPPY WITH THE SERVICES PROVIDED BY THIS COMPANY, PLEASE CALL (239) 541-9480. WE WILL RESPOND WITHIN 2 BUSINESS DAYS. IN THE EVENT YOUR COMPLAINT IS NOT RESOLVED TO YOUR SATISFACTION, YOU CAN CONTACT OUR ACCREDITING ORGANIZATION: THE COMPLIANCE TEAM AT [WWW.THECOMPLIANCETEAM.ORG](http://WWW.THECOMPLIANCETEAM.ORG) OR BY CALLING 888-291-5353.

**We will exchange or return any off the shelf products, for any reason, within 30 days of delivery date and refunds will be issued for such merchandise. Off the Shelf items must be returned in re-salable condition, in the original boxes. Dirty or used looking items will not be accepted. Returns after 30 days and Custom Order Items are subject to fees. Custom Items MAY NOT be returnable. We will repair or replace, free of charge, all Medicare covered equipment that is under warranty. Note Custom inserts are non-returnable, there for you will be held for any and all cost of the inserts.**

### **Instruction to Patient-Return Demonstration Acknowledgement**

I acknowledge receiving instructions in the proper use and care of the equipment and/or supplies described. I have had my financial responsibilities explained. I also acknowledge and agree to this entire agreement.

I have read and acknowledged the above information.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Fitter \_\_\_\_\_

Date \_\_\_\_\_