Family Footcare, PC

Milton Stern, DPM - Randy Kaplan, DPM - Cindy Pavicic, DPM

Date: ________________________________

Delivery Documentation and Break-In Instructions

Congratulations on receiving your new shoes. In accordance with Medicare regulations, they have been selected from our own inventory, from another company or have been fabricated to provide you with optimum comfort and protection.

Getting used to your shoes: People with decreased feeling in their feet may have a false sense of security as to how much at risk their feet actually are. An ulcer under the foot can develop in a couple of hours even if the shoes are expertly fit. In order to best avoid irritation, adhere to the following break-in schedule:

FIRST DAY: Wear One Hour

SECOND DAY: Wear Two Hours – Check feet after first hour

THIRD DAY: Wear Three Hours

FOURTH DAY: Wear Four Hours – Check feet after two hours

FIFTH DAY: Wear Full Day – Check after lunch·

IF AT ANY TIME YOU SEE RED SPOTS OR DARKNESS ON THE TOES OR OTHER BONY AREAS DURING THE FIRST FIVE DAYS: Discontinue wearing the shoes for the rest of the day and start routine again the next day beginning with one hour of wear.

IF A RED SPOT OR DARKNESS APPEARS WITH EVERY WEARING: DO NOT WEAR SHOES. Call our office for an adjustment appointment.

BE SURE TO INSPECT YOUR FEET EVERY DAY.

Follow-Up You should have regularly scheduled visits with our office. Please direct any questions to this office. Billing questions may be directed to your Medicare carrier. Every four months get rid of the inserts in your shoes and put in a new pair. In one year, you will receive a reminder to return to our office to evaluate the condition of these shoes.

Return Policy: Shoes that are unsuitable may be returned within one week of dispensing. The shoes must be in good condition, i.e., no scuffmarks, outside dirt or obvious wear on the soles and in original packaging. We strongly urge you to wear these shoes in your home for the first week. Substandard shoes may also be returned as all warranties, expressed and implied under applicable State law will be honored. I certify that I have received the item(s) marked below in good condition. The Doctor has explained, in detail, the proper use and care of this device and has fit it to me. The Doctor has asked me to call the office if I encounter any problems with the device or if I have any questions. I have been informed of the Medicare DMEPOS Supplier Standards.

Patient Signature:____ Date____________

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