RICHIE BRACE® AFO RECEIPT

Name of Practitioner: _____

Address of Practitioner: _____

City, State, Zip: _____

Patient's Name: _____

Patient's Address: _____

Medicare Number: _____

Date of Dispensing: _____

Doctor _____ has dispensed:

☐ One Hinged Ankle Custom Ankle Foot Orthosis HCPC Code L1970 for Left / Right (circle Left or Right or both) Foot *with:*

(check all that apply)

☐ Soft Tissue Padding Below the Knee: L2820

☐ Varus/Valgus Correction: L2275 (applicable with arch suspender only)

☐ Orthotic Plate Accommodation: L3480 (applicable with arch suspender only)

☐ Dorsiflexion Assist: L2210 x 2 (applicable on Dynamic Assist only)

☐ Anterior Tibial Shell (optional): L2320

The above item(s) fits well, and is comfortable. I have received written instructions on how to use and care for them from Dr. _____ . The warranty period is 6 months for hardware components (hardware, plastic, and metal components) and 90 days for all soft materials (crepe, top-covers, Velcro limb support pads). I have read the posted Complain Resolution policy and have been provided with a copy of the abbreviated 21 Medicare Supplier Standards. I understand that failure to properly care for these items will result in the warranty being void. This could result in my responsibility for future repair or replacement costs if my insurance policy will not cover such costs.

Patient's Signature _____ Date _____