ProHealth & Fitness PT OT – Physical and Occupational Therapy
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PATIENT NAME: _____

DATE OF INITIAL SESSION: _____

APOS ID #: _____

I was thoroughly evaluated, fitted for, and have had the APOS shoes calibrated specifically for me and my issues, and:

- I have received the instructions, understand them, and will follow as directed
- I have received the precautions and contraindications and will follow them
- I understand that my doctor will need to sign a prescription for authorizatiion
- I understand that the shoes will be mailed from the APOS warehouse*
  - *Pending full approval authorization if not yet received
- I understand that once delivered, I will return to get my shoes, try on, and begin
- I understand that I am required to participate in 5 follow up (FU) appointments
  - I understand that I need to come to the clinic for my FU appointments
- I understand that my provider/office will call me to schedule my FU appointments
  - If my number changes, I will advise the clinic of the new number
- For any issues with my APOS shoes, it is my responsibility to call immediately

PATIENT NAME:	_____	PROVIDER:	_____
SIGNATURE:	_____	SIGNATURE:	_____
OTHER:	_____	SUPERVISING PROVIDER:	_____
DATE:	_____/_____/_____	DATE:	_____/_____/_____

FOR OFFICE USE ONLY:

Administrative staff: _____ Adm signature: _____