# ORTHOTIC REPLACEMENT PROGRAM

SOLO Laboratories, Inc. offers an ORTHOTIC REPLACEMENT PROGRAM to provide you with new orthotics in the event your current devices are lost, stolen, damaged beyond repair, or outgrown. The purchase of this program entitles you to two (2) new orthotic devices (one pair) for the term of 24 months. (Variations from the original design may incur additional charges. Check with your doctor to see if this applies to you.) This program does not cover your doctor's fees or casting charges.

To enroll, please complete the form below and return it to SOLO Laboratories, Inc. with your payment of $90.00. Applications must be received within 60 days of receipt of your orthotics. You will receive a certificate from SOLO indicating coverage from the date you received your orthotics to the expiration on the certificate.

To make your claim, your doctor must return your outgrown or broken orthotics and include the certificate with a new cast, foam box, or scan. If you are unable to return the orthotics for any reason, there is an additional charge of $40.00 per pair or $20.00 per device. This charge will be refunded if the original devices are returned within three (3) months of the claim date. All claims must be signed by your doctor before fabrication begins.

The plan does not cover items such as top covers, extension, bases, and other fabric or material. These can be replaced at an additional nominal cost.

## Please Complete the Entire Form

**Patient's Name:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Order Number:** _____ **Orthotic Date:** _____

Please send my certificate: ☐ via email to _____ ☐ via mail to the above address

**Doctor's Name:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Payment Method:** ☐ Check Enclosed ☐ Credit Card/Debit Card ☐ Health Savings Account (HSA) ☐ Flexible Spending Account (FSA)

**Name** (as it appears on the credit card): _____

**Credit Card Number:** _____

**Expiration:** _____ **Security Code:** _____

Enclosed is my payment of $90.00 made payable to SOLO Laboratories, Inc. I understand and accept the terms and policies of the ORTHOTIC REPLACEMENT PROGRAM.

**Signature** (Parent/Guardian): _____

## For Lab Use Only

Authorization Number: _____ Date Received: _____

Payment Type: ☐ Check ☐ Credit Card/Debit Card ☐ HSA ☐ FSA