PROSTHETIC DELIVERY FORM

Delivery Date: _____ AK _____ BK _____ BIL _____

Patient's Name: _____ DOB: _____

Delivery Address: _____

Home _____ Office _____ Nursing Facility _____ Skilled Nursing _____ Other _____

Type of Service Rendered: _____

Supplies Received:

QTY	Item	Manufacturer
_____	Cover: BK L5704 ___ AK L5705 ___	_____
_____	Skin: BK L5962 ___ AK L5964 ___	_____
_____	Sock (Multi-ply): BK L8420 ___ AK L8430 ___	_____
_____	Sock (Single-ply): BK L8470 ___ AK L8480 ___	_____
_____	Shrinker: BK L8440 ___ AK L8460 ___	_____
_____	Locking Gel Liner: L5673 ___	_____
_____	Non-locking Gel Liner: L5679 ___	_____

Notes: _____

_____

I am satisfied with both the workmanship and fit of the device at the time of delivery. I have also been fully advised as to the use of the appliance and understand its limitations. I also understand a guarantee on components, (except shoes, stump socks and sheaths), under normal use, is extended for six months after delivery, during which time the company will make any repairs necessary to maintain the appliance in good working condition.

Warranty | Your custom device has been fabricated to your individual measurements, correct alignment and proper fit, corresponding with your anatomical conditions at the time of measurement and fitting. Norell Prosthetics Orthotics, Inc. warrants your device to be free from defective fabrication and components, under normal service and use, for 90 days from the delivery date. (Exceptions to this warranty include, but are not limited to: prosthetic skin covering, non-custom items/accessories such as prosthetic socks, straps, etc. and adjustments needed due to anatomical or other medical changes. The obligations under this warranty are limited to repair or replacement, at no charge, if the component is determined defective by Norell Prosthetics Orthotics, Inc. Please call our office at (510) 770-9010 to schedule an appointment.

This warranty becomes void immediately if: 1) The device has been adjusted, altered or repaired by anyone other than an employee of Norell Prosthetics Orthotics, Inc. 2) The device has been subjected to misuse, negligence or accident. 3) The patient fails to fulfill responsibilities outlined above.

I also understand that Norell Prosthetics Orthotics, Inc. will attempt to collect from my third-party payer. I am aware that the charges are ultimately my responsibility to pay including any additional fees it may take to resolve any dispute with regards to collections.

_____ _____ _____ _____

Signature of Patient/Authorized Rep or Witness Date Signature of Orthotist/Prosthetist Date

Office Address:

____ 48521 Warm Springs Blvd #305, Fremont, CA 94539

____ 735 Sunrise Ave Ste 101, Roseville, CA 95661

____ 5466 Complex St Ste 207, San Diego, CA 92123