

# LAKE SHORE CLINIC

VIP treatment, better care

## Orthotic Repair Request

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First MI

Guarantors Name: \_\_\_\_\_  
(If patient is under 18 years of age)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Numbers: \_\_\_\_\_ - Primary  
\_\_\_\_\_ - Secondary

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I, \_\_\_\_\_ am returning orthotics to Lakeshore Clinic,  
Please Print Name of Patient  
/ Peter Lallas, DPM to have them repaired by Northwest Podiatric Laboratory. I understand that there will be a charge for this service and agree to pay any and all fees associated with this repair. Any questions regarding the billing may be addressed to Lakeshore Clinic Billing Office at 425-485-3955.

I, \_\_\_\_\_ am requesting that Dr. Peter Lallas submit an  
Please Print Name of Patient  
order for an additional pair of custom orthotics. I understand that there will be a charge for this service and agree to pay any and all fees associated with this repair. Any questions regarding the billing may be addressed to Lakeshore Clinic Billing Office at 425-485-3955.

\_\_\_\_\_  
Signature of Patient of Guarantor (If patient is under 18 years of age)

\_\_\_\_\_  
Date