FORMS Policy: Medical, FMLA, Disability, Insurance, etc.

Please take a moment to read through this form. Only completed and signed forms will be processed. Any missing information will cause a delay and/or for your incomplete forms to be returned by mail to the home address we have on file.

- There is **a $35 fee for each** form that needs to be completed by our office.
- Please allow **10 BUSINESS DAYS** to process your request.
- Medical forms **WILL NOT be completed during your office visit with the doctor**.
- Our providers **WILL NOT** fill out disability paperwork unless your doctor has given you a note taking you out of work
- Patients who **have not been seen in six weeks** or more **MAY** be asked to schedule an appointment with their doctor prior to completion of forms.
- A completed and signed authorization form is required prior to completion. Please make sure you have **completed and signed** this form. (*Attached*)
- If you want forms to be sent to someone other than yourself, please make sure you list this information on the portion of the form labeled FORM STATUS.

The Completed medical release and fee must be received at the time the request is made to process your forms. Again, please allow 10 business days to process your request. When your forms are completed, someone from our office will contact you.

DATE REC'D BY COSM _____

INITIALS _____

CHART # _____

DOCTOR _____

MEDICAL, FMLA, & DISABILITY FORMS

PLEASE ALLOW UP TO 10 BUSINESS DAYS TO COMPLETE YOUR FORMS.

Please make sure this form is completed in its entirety

PAYMENT

There is a fee for each form that we fill out.

☐ I agree to pay the **$35 fee for each form** requested to be filled out by my provider.

ACCIDENT/FMLA/DISABILITY FORM

Patient's Name: _____ DOB: _____

Patient Address: _____City_____State_____Zip_____

Daytime Phone # _____ Secondary #_____

Concerns Which Body Part(s): _____

Job Description: _____

Date(s) Out of Work: _____ Return to Work: _____

I hereby authorize the release of these forms and/or medical records related to: _____ (body part(s) Rt, Lt, Bil)

Dated from (date of injury): _____ to ___present___

Patient's Signature: _____Date:_____

FORM STATUS Please choose carefully, fill out completely, or release may be delayed

☐ PATIENT WILL PICK UP FORM FROM (Circle): **Cary Pkwy Ortho** **Cary Ortho Spine** **Davis Drive** **Holly Springs**

☐ MAIL FORM TO PATIENT (Address) _____

☐ EMAIL FORM TO PATIENT (Email Address) _____

☐ FAX TO PATIENT AT FAX # _____

☐ FAX TO THE FOLLOWING:

COMPANY NAME: _____ PHONE #_____

(Where you want the forms sent)

ATTN: _____ FAX # _____

☐ MAIL TO THE FOLLOWING:

COMPANY NAME: _____ ATTN: _____

(Where you want the forms sent)

ADDRESS: _____

THIS AUTHORIZATION MAY NOT BE VALID FOR GREATER THAN ONE YEAR FROM THE DATE OF SIGNATURE. YOU MAY REVOKE OR TERMINATE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REVOCATION TO OUR OFFICE. THIS INFORMATION MAY BE RE-DISCLOSED BY THE RECIPIENT.

CARY ORTHOPAEDIC STAFF ONLY

CASH/CHECK/CREDIT CARD $ _____ DATE: _____ CHARGES POSTED BY: _____ ON _____