Advanced Surgical of North Texas

PATIENT FORM POLICY

PURPOSE

The purpose of the policy is to ensure that all forms requiring a physician signature are completed in a timely manner and appropriate procedures are followed in the processing of forms.

Information and Procedures

Any documentation that needs to be completed with medical information and requires a physician signature including FMLA, Disability, Insurance Requests

Please READ and INITIAL the following statements:

_____Processing time is 7 to 10 business days. They will be completed in the order they are received. We understand at times there may be an urgency with some form completion and will do our best to accommodate.

_____ Forms may be dropped off at either office location, mailed or faxed. ***Prepayment is required before forms are completed.***

_____ Blank forms will not be accepted. Personal information must be completed.

It is our office policy to charge for the completion of any form as follows:

-Processing fee of $15 per form. If needed more urgently we can USUALLY expedite processing to 2-3 days, the fee for rush processing is $25.

-If the form is lost or needs to be revised an additional $10 fee for reprocessing will be applied

-There is a $1 charge if the form is to be mailed back.

Completed forms: Completed forms may be faxed, mailed or picked up in person.

Patient Signature:_____ Date: _____

Advanced Surgical of North Texas

Today's Date:_____

We are happy to assist you in completing your Disability and FMLA forms. Be advised there is a 7-10 business day processing time frame.

By law we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

*Patient Name: _____ DOB: _____

First Day of Leave: _____ Estimated Length of Leave: _____

I authorize Advanced Surgical of North Texas to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefits amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I also acknowledge I am responsible to pay the form completion fee prior to form completion.

Signature:_____ Date: _____

*****OFFICE STAFF ONLY BELOW*****

☐ Payment Collected _____ Initials

☐ I approve this form completion