Patient Form Fee Guidelines

Date:_____Physician's Name:_____

DOB: _____ Patient's Name:_____

MRN:_____ Patient's Phone: _____

Please READ and INTIAL the following statements:

Vascular Surgical Associates office fees for the completion of any form which requires medical information and/or a physician's signature.

_____ The fees are as follows:

- **Disability Paperwork: $40**
- **Handicap Parking Permit (Notarized): $5**
- **FMLA (Family Medical Leave Act) Forms: $40**

_____ If you are requesting FMLA paperwork to be completed, what dates are you requesting to be off from work? _____ thru _____.

_____ If the physician requires additional information to complete this form, the patient may need to schedule a follow up appointment. In such case, we will contact you directly. Please ensure the contact phone number above is accurate. If an appointment is required any portion of the visit not covered by your insurance will be your responsibility and due at the time of service.

_____ As detailed above, prepayment is required at the time of submission to process disability, handicap or FMLA forms. A $0.50 fee will be added for mailing completed forms.

_____ Vascular Surgical Associates office requires at least 5 business days for the completion of any form. If additional documentation is needed, there may be delays. The office will contact you with any updates or upon completion of submitted forms. Please do not attempt to collect the forms prior to being notified by the office.

_____ I have been informed by staff that my physician:

_____ Is available in the office during the next 5 business days

_____ Is out of the office until_____.

Patient/guardian Signature: _____

Thank you for your cooperation and participation in your care.

Office staff: Please log this form into the patient's chart, attach this form to the paperwork brought in by patient, and place it in the hands of the corresponding MA assigned to the doctor.

How did we receive this paperwork? Fax _____Patient drop off_____ Other _____

Initials of office employee who received: _____ Date:_____