Advanced Orthopedic Specialists, P.C.
Providing state of the art orthopedic care in a friendly environment
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Form Policy

Date: _____

Dear Patient:
This letter is to introduce you to our office policy concerning the processing of your insurance or disability form.

- **There is a $10.00 charge for processing each form.** This fee must be paid before the completed form is released from our office.
- Forms may take up to **three to five business days** to complete.
- As a courtesy, we will mail your form to **one** place **or** fax it to one place, **or** you may pick it up.
- **Your form will be filled out according to the information you provide below.** Please give as much information as possible.

CHOOSE ONE OF THE FOLLOWING

_____ Picked Up

_____ Mailed If so, to where? _____

_____ Faxed Fax number: _____

Patient Name: _____DOB: _____

Daytime Phone Number: _____

First Date of Disability: _____ Expected return to work date: _____

Body part form is pertaining to: Right or Left: _____

Notes: _____

_____

Office use only:
PAID: YES_____ NO _____ # of forms: _____
Amount paid: _____ Initials: _____ LAF RMM MJC