

Disability/FMLA/Special Reports Request

Section A (To Be Completed by the Patient)

Patient Name: _____ DOB: ____/____/____

Name of person requesting special report/FMLA (if other than patient): _____

Physician: _____ Requesting (please circle): Disability / FMLA / Other

Credit Card #: _____ Exp: _____

Please Note:

A minimum of \$50 will be charged for the completion of any forms ranging from 1-5 pages (includes disability, FMLA, and any other special reports). An additional fee of \$10 will be charged for each additional page thereafter, and will not include the cost of sending any additional records. The typical range is \$50-\$80. **This fee is NOT covered by the Advance Program.**

In order for your provider to complete **any forms** regarding your disability status, you must have received treatment at the Diamond Headache Clinic **within the previous three months. You must also discuss your request with your physician during your office visit.**

In order for your forms to be processed, a signed and valid authorization must be submitted allowing your provider to release confidential health information. If you need to complete an authorization form, you may find a copy at www.diamondheadache.com

The processing time for disability/FMLA forms is **10-15 business days** after all necessary forms, payment, and authorization are received at the Diamond Headache Clinic.

Section B (To Be Completed by the Diamond Headache Clinic)

Date this form and all forms to be completed received by Diamond Headache Clinic: _____

Release of Information received and/or valid copy on file? YES / NO

Has the patient been seen in the office at least three times? YES / NO (req. for authorization of disability)

Does the patient's physician approve their disability/FMLA request? YES / NO

Total Charge: \$ _____ Payment has been collected? YES / NO

Comments:

MD Cleared	<input type="checkbox"/>
Harriet Clear	<input type="checkbox"/>
Paid	<input type="checkbox"/>
In Progress	<input type="checkbox"/>
Complete/Scan	<input type="checkbox"/>

Date forms completed: _____ fax / mail / email / other: _____ Emp. Initials: _____