excellence in brain, spine and pain care
neuroscience group

Amount Collected $ _____

Initials _____

For internal use only.

Patient Form Completion Request

Please answer all questions on this form. Not answering every question may result in a delay in your request.

1. PATIENT INFORMATION:

_____

Name Address City State Zip

_____ (_____)_____ _____

Date of Birth Daytime Phone Number Previous Name

2. YOUR PROVIDER'S NAME (Doctor, Nurse Practitioner (NP) or Physician's Assistant (PA))_____

3. TYPE(S) OF FORMS REQUESTED

☐ FMLA $20 ☐ DISABILITY $10 ☐ CAMP FORM $10 ☐ INSURANCE $10

☐ OTHER_____

4. DID YOU MISS ANY WORK?

☐ YES ☐ NO ☐ Not Applicable

If yes, what dates? _____

Reason for missed work: _____

5. HAVE YOU HAD SURGERY PERFORMED BY A NEUROSCIENCE GROUP PROVIDER IN THE LAST 90 DAYS?

☐ YES ☐ NO

6. DO YOU HAVE A SCHEDULED UPCOMING SURGERY WITH A NEUROSCIENCE GROUP PROVIDER?

☐ YES ☐ NO

7. HOW WOULD YOU LIKE TO RECEIVE YOUR FORM?

☐ Myself (select delivery option below) Send to a third party: _____

☐ Mail to my address above ☐ Pick up (Photo ID required.) Attn: _____

If to be picked up by another, I hereby authorize Address: _____

_____ to pick up my form(s). Fax: _____

(Photo ID required)

8. DATE FORMS NEED TO BE RECEIVED BY: _____

(Please allow 10 -14 business days for forms completion)

9. DISCLAIMER: I have the right to inspect and receive a copy of health information I have authorized to be disclosed by this authorization. I understand that I may be charged a fee for records copies. I understand that I do not need to sign this Authorization to receive treatment. I am aware that I may revoke this Authorization by notifying the medical records department in writing. This revocation will not affect information that has been disclosed prior to receipt, or if the disclosure is authorized by law the authorization was a condition for obtaining insurance coverage. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by law.

10. Patient Signature: _____ **Date:**_____