FOX VALLEY ORTHOPEDICS

CHECK ONE:

☐ **DISABILITY FORM - FEE $25.00**

☐ **FMLA (Family & Medical Leave Act) FORM - FEE $25.00**

☐ **OTHER (i.e. Aflac, Travel Form, etc.) - FEE $25.00**

Dear Patient:

The attached authorization form is used in addition to the form provided to you by your insurance company or employer.

Please complete and sign the attached authorization. Without proper completion, we will be unable to process your paperwork.

There is a $25.00 fee for each form, Disability, FMLA, etc. Payment is due prior to completion of your form. Please allow up to 5 business days to process this paperwork.

The HIPAA privacy rule establishes standards to protect your individual identifiable health information that will be provided to your insurance company. Your cooperation in the completion of the attached authorization will guarantee your form to be completed in a timely manner.

If you have any questions, please feel free to contact us.

Thank you,

Medical Records Department: (630) 584-1400/x1808

Please submit to one of the following:

Drop off at front desk - Gen/Kaneville or Gen/Soderquist, or Elgin/Lin Lor
Mail: 2525 Kaneville Rd, Geneva, IL 60134
Fax: 630-584-1733
E-mail: info@fvortho.com

REQUEST TAKEN BY:_____

REVISED 3/2023

FOX VALLEY ORTHOPEDICS

Disability / FMLA Authorization

Instructions for using this form
1. Please print all information clearly.
2. To avoid delay, be certain that ALL information given is correct.
3. Attach your company form to this authorization (be sure you have signed both forms) and return to our Medical Records Dept.

TO BE COMPLETED BY INSURED (PATIENT)				
NAME (Last, First, Middle)			**DATE OF BIRTH**	
ADDRESS				
NAME OF PERSON APPLYING FOR FMLA (IF NOT PATIENT)				
NAME OF DISABILITY INSURANCE COMPANY OR FMLA EMPLOYER				
WHERE COMPLETED FORMS ARE TO BE SENT (Company Name)				
ATTENTION				
ADDRESS				
CITY/STATE/ZIP				
OCCUPATION	**WORK DUTIES:**	**WALKING**	**SITTING**	**LIFTING**
NATURE OF DISABILITY (CHECK ALL THAT APPLIES):		**ILLNESS**	**INJURY**	**ACCIDENT**
DATE OF INJURY OR BEGINNING OF ILLNESS		**LEAVE REQUESTED:**		
NAME OF DOCTOR TREATING YOU (AT OUR OFFICE)		**CONTINUOUS DISABILITY**		
		INTERMITTENT LEAVE		
I AUTHORIZE FOX VALLEY ORTHOPAEDIC INSTITUTE TO RELEASE ANY INFORMATION REQUIRED IN COMPLETING THIS FORM Unless specifically excluded, this authorization includes the release of information by mail, fax, phone, or otherwise to ensure proper payment.				
SIGNATURE OF THE INSURED (PATIENT)			**DATE**	
OFFICE USE ONLY - DISABI $25	**FMLA $25**	**OTHER $25**	**REQUEST TAKEN BY:**	**DATE:**

Revised 3/2023