FOX VALLEY ORTHOPEDICS

2525 Kaneville Road, Geneva, Illinois 60134 630-584-1400
2535 Soderquist Court, Geneva, Illinois 60134 630-584-1400
1975 Lin Lor Lane, Plaza Suite, Elgin, Illinois 60123 847-468-1400

CHECK ONE

☐ **DISABILITY FORM - FEE $25.00**

☐ **FMLA (Family & Medical Leave Act) FORM - 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 and FMLA. Payment is due prior to completion of your form. Please allow up to 5 business days to process this paperwork. We will contact you to let you know when the paperwork has been completed per your instructions.

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

Phone: 630-524-0104
FAX: 630-584-1733

REQUEST TAKEN BY:_____

FOX VALLEY ORTHOPEDICS
2525 KANEVILLE ROAD • GENEVA, IL 60134
PHONE: 630-524-0104 • FAX: 630-584-1733

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 ONE)		**ILLNESS**	**WORK INJURY**	**ACCIDENT**
DATE OF INJURY OR BEGINNING OF ILLNESS		**LEAVE REQUESTED:**		
NAME OF DOCTOR TREATING YOU (AT OUR OFFICE)		**TOTAL 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 - DISABILITY FORM $25	**FMLA FORM $25**	**REQUEST TAKEN BY:**	**DATE:**	