College Park Family Care Center, P.A.
Specialty Office

FORM FEE GUIDELINES

Date:_____ Provider's Name:_____

Patient Name:_____ Date of Birth:_____

Patient/Guardian Contact Phone Number:_____

Please ***READ*** and ***INITIAL*** the following statements:

College Park Specialty Office charges a fee for the completion of any form which requires medical information and/or a physician's signature.

_____The fees are as follows:

- Handicap Parking Placard Form: $5
- Disability Paperwork: $10-$65 (Based on length and required detail.)
- FMLA (Family Medical Leave Act) Forms: $40-$65
- If you are requesting FMLA paperwork to be completed, what dates are you requesting to be off of work?_____thru_____

_____Pre-payment is required in order for our office to mail the forms. There will be an additional $.50 charge for postage and handling.

_____ If the doctor feels it is necessary to obtain more information from the patient in order to complete the form, the patient may be required to make an appointment. If this is the case, we will contact you. (Please complete contact phone number above.)

_____College Park Specialty Office requires at least **5 business days** for the completion of any form. After this time, your form will be available for pick-up at our Check-Out window. If it is completed sooner, we will contact you.

_____If copies of your medical records are needed to complete this form, the Release of Information form (page 2) must be completed.

_____I have been informed by the receptionist that my doctor:

_____Is/will be in the office today.

_____Is out of the office until_____.

Patient/Guardian Signature:_____

Thank you for your cooperation.

Front Office: Please log this form into the Form Log, attach this form to the paperwork brought in by patient, and place in the doctor's mailbox. If Disability – send to Central Medical Records.
How did we receive this paperwork? FAX_____Patient Drop-Off_____Other_____
Front Office Initials:_____Date:_____

College Park Family Care Center
Midwest PHYSICIANS®

Medical Record Release Authorization

(For Use With Form Completion Request Only)

Patient Name _____Maiden/Previous Name_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address _____ City/State/Zip_____

Email Address: _____

A) I authorize the release of records FROM:

COLLEGE PARK FAMILY CARE CENTER

Provider:_____

B) To be released as required and outlined in the form submitted with this signed authorization, specifically to the following treatment and date/ range:_____

_____

_____

_____

_____

Release To:

C) For the purpose of:

___Disability/FMLA

___Insurance

___Work Comp

___Other Explain:_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this realease form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

The authorization will expire one year from the date above unless I specify an expiration date: _____

(Expiration date of authorization)

Office staff: scan forms to monthly file. Do not send to CMR for processing.