ELMHURST ORTHOPAEDICS

DIAGNOSTICS • TREATMENT • REHABILITATION

PH: 630-834-0491 www.elmortho.com

Form Completion Request

***SECTION A: FOR PATIENT/GUARDIAN TO COMPLETE*:**

Patient Name: _____ Patient DOB:____/____/____

Physician: Bartucci MD Nikoleit MD Koutsky MD Noorlag DPM

I request to have the following form(s) to be completed. Completed form(s) will be:

- ❑ Picked up at Elmhurst office by _____ , _____.
  (Name of authorized person) *(Relationship)*
- ❑ Faxed to: _____Attn: _____ Fax Number : (_____)_____-_____
  (*Company name)*
- ❑ Mailed to:_____

  _____

  _____

_____ *Handicapped Parking Form* - No Charge

_____ *FMLA*, *Disability, Physician Statement* or any Other Misc Form(s) - $20.00 fee pre-paid

# of pages to be completed _____ **TOTAL FEE DUE:** _____

Check one: Payment Options:

- ❑ Pay in office in person (Credit Card, Check or Cash)
- ❑ Pay over the phone by Credit Card

I understand it will take 7-10 business days for forms to be completed. I understand that payment for these services via cash, check, or credit card will be necessary *before* forms can be completed and distributed. I authorize the release of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous diagnosis/treatment, infectious/contagious disease information, and/or information about drug, alcohol, or substance abuse or treatment of same) of myself or my dependents to the named party as specified above. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient (or Parent/Guardian if patient is under 18 yrs old) **Date of Request**

SECTION B: FOR ELMHURST ORTHOPAEDICS STAFF TO COMPLETE

Payment collected by _____/EO Patient paid via: *credit check cash* on _____/_____/_____. **Patient #** _____

SECTION C: TO BE COMPLETED AT TIME OF PICK UP, FAX, OR MAILING

Circle one: **Faxed Mailed** or **Picked up** by _____ _____

Signature of Patient or Authorized Person **Printed Name**

_____

Date