TRI COUNTY ORTHOPEDICS, P.C.

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GENERAL ORTHOPEDICS ° SPORTS MEDICINE ° JOINT RECONSTROCTION ° HAND SURGREY
ARTHROSCOPIC SURGERY ° TRAUMAOLOGY

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Form Policy

Date: _____ Patient Name: _____ DOB: _____

Dear Patient,

This letter is to introduce you to our office policy concerning the processing of the insurance or disability form.

- **There is a $10.00 charge for processing each form.** This fee must be paid before the completed form is released from our office.
- Forms may take up to **five to seven business days** to complete.

Please select one of the following:

___ Pick Up-Phone Number: _____

___ Mail-If so, to where? _____

___ Fax-Fax number: _____ Attention to: _____

First Date of Disability: _____ Expected return to work date: _____

Body part for is pertaining to: Right or Left _____

Note: _____

_____

I hereby authorize release of my records from Tri County Orthopedics, P.C. to _____.

Signature: _____ If guardian or DPOA, state relationship: _____

Office use only: Paid: Yes No #of forms:___
Initials: _____