SPORTS MED Wheaton Orthopaedics Ltd.

www.sportsmedltd.com

Form Completion Request

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

Patient Name: _____ Patient DOB:____/____/____ MD: Baker Choi Erickson Felske

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

- ❑ Picked up in Carol Stream/Naperville by _____ , _____.
  (Circle One location) *(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) 1-2 Pages = $10
3 or more pages = $20

# of pages to be completed _____ **TOTAL FEE DUE: $ _____.00**

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 SPORTSMED WHEATON OTHERPOAEDICS STAFF (PSR) TO COMPLETE
Payment collected by _____/PSR 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