



# Northeast Orthopedics, Inc.

## Orthopedic Surgery and Sports Medicine

164 Wetherby Lane, Westerville, Ohio, 43081 ph: (614) 839-2300 fax: (614) 839-2301

### DISABILITY / FMLA FORM POLICY

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_  
Phone # : \_\_\_\_\_  
Fax # : \_\_\_\_\_

Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone # : \_\_\_\_\_  
Fax # : \_\_\_\_\_

Effective 11-01-06 a \$20.00 processing fee will be charged for EACH disability form received by our office for completion. This does not include BWC.

Your form will be released upon receipt of payment. Checks may be made payable to Northeast Orthopedics, Inc.

Please allow 2 wks for completion.

In order for your form to be completed, you must have filled in and signed your portion of the form.

If you have questions, please do not hesitate to call the office. Thank you in advance for your time and cooperation.

Sincerely,  
The Physicians and Staff at Northeast Orthopedics

For Office Use Only

Release Signed   
Request for Payment Sent Date: \_\_\_\_\_ Method: Mail Fax Phone In Person Initials: \_\_\_\_\_  
Payment Received Date: \_\_\_\_\_ Method : \_\_\_\_\_ Amount: \_\_\_\_\_ Initials: \_\_\_\_\_  
Form Completed Date: \_\_\_\_\_ Initials: \_\_\_\_\_  
Form Sent Date: \_\_\_\_\_ Method: Mail Fax In Person Initials: \_\_\_\_\_