Dear Patient or Advocate:

Thank you for choosing Southwest Orthopaedic Speciaists for your healthcare needs.

There is a $35.00 charge for completion of medical forms that must be paid in advance and prior to completion of the forms.

We can accept payments of Cash, Check, Money Order or Credit/Debit Card.
Please DO NOT send cash in the mail.

All payments can be made at OR mailed to our South OKC office:
Southwest Orthopaedic Specialists, PLLC
Attention: FORMS
8100 S. Walker Bldg A
Oklahoma City, OK 73139

Payment can be made over the phone if paying by Credit/Debit Card by contacting us at:
405-632-4468 x1070

Once payment has been received, please allow **10-14-business days** for completion of the forms.

FOR OFFICE USE ONLY – Credit/Debit Card

Name on Card (PLEASE PRINT): _____

Card Number: _____ Exp: _____ CVV: _____

Address on file with Creditor: _____

_____

By signing below, I authorize Southwest Orthopaedic Specialists to charge my credit card in the amount of $35.00 for forms completion services.

Card Holder Signature: _____ Date: _____

Southwest Orthopaedic & Reconstructive Specialists

FMLA-STD FORMS INFORMATION

NOTE: There is a $35.00 charge for completion of medical forms that must be paid in advance.

PLEASE FILL IN ALL INFORMATION COMPLETELY AND ACCURATELY

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____

PATIENT PHONE: _____ SSN: _____

TREATING PHYSICIAN: _____

WHERE DO YOU NEED THE FORMS TO GO TO?

COMPANY NAME: _____

ATTENTION TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

ADDITIONAL INFORMATION NEEDED:

WORK RELATED INJURY? YES / NO

Please choose from the following:

1. Continuous Leave Start Date: _____

   Projected Return to Work Date: _____

2. Intermittent Leave Start Date: _____

If you have been told not to return to work by your doctor or have been scheduled for surgery, what is the first date of work that you missed or will miss?

DATE: _____

By signing below, I hereby give Southwest Orthopaedic Specialists authorization to process payment and send appropriate medical information to the above named entity.

Patient/Advocate Signature: _____ Date: _____

Southwest Orthopaedic & Reconstructive Specialists
southwestortho.com

8100 S. Walker Avenue, Building A
Oklahoma City, OK 73139
Local: 405.632.4468
Toll Free: 877.332.4468
Fax: 405.619.4426

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Phone: _____ Social Security Number: _____

I hereby authorize **Southwest Orthopaedic & Reconstructive Specialists** to release the following information to:

_____	_____	_____
Name of Person/Organization Receiving PHI	Phone	Fax

_____	_____	_____	_____
Address	City	State	Zip Code

Information to be shared:

□ Progress Notes □ Procedure Reports □ Radiology Reports □ Entire Medical Record

□ Medical information compiled from _____ (insert date) to _____ (insert date)

□ Billing Information for: _____ □ Other: _____

The information may be disclosed for the following purpose(s) only: _____

_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____.

_____	_____
Signature of Patient or Legal Representative	Date

_____	_____
Description of Legal Representative's Authority	Expiration date (*if longer than one year from date of signature or no event is indicated*)

Delivery/format: □ US mail □ Will pick up □ Fax □ CD

* Please mail or fax the completed Authorization form to SOS at the address or fax number listed above.