INOV8 Orthopedics

Account #_____
Date: _____

10496 Katy Freeway, Ste 101 Houston Texas, 77043 Ph (346) 571-7500 / Fax (713) 492-2440

Request for Form Completion

Pre-Payment is REQUIRED.

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_____

Patient Name:_____
(Last) (First) (Middle / Maiden)

Address:_____

City:_____ State:_____ Zip:_____

Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #:_____ Cell/Work #: _____

Physician:_____ Body Part:_____

Date Injury/Problem Began:_____ Last Day to Work:_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_____

Please check a reason: ☐Continuous Leave ☐Surgery and Post-Op Treatment ☐Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work: FROM:_____TO:_____

Please allow 7-10 business days for completion of form AFTER PAYMENT RECEIVED.

I authorize Inov8 Orthopedics to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:_____
(i.e. Self / Family Member / Insurance / Employer)

Address:_____

City:_____ State:_____ Zip:_____

Telephone #:_____ Fax #: _____

Please check your preferred method of release:
☐ Mail the form to the patient's address ☐ Mail the form to the name/organization above
☐ Fax the form to number provided above
☐ I will pick-up the form. **A representative from our office will contact you to coordinate a designated date & time to pick up forms*
☐ I will have someone pick-up the form for me: Name _____Relationship: ☐ Spouse ☐ Parent ☐Child ☐ Other

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying Inov8 and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Inov8 before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. *This authorization will expire in 1 year or when I am released from my treating provider at Inov8.*

Signature:_____ Date:_____
Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____

Please check form type: ☐Disability / 99080D $25.00 **each** ☐FMLA / 99080F $25.00 **each** ☐Postage / 99080P $6.70

Total Due: _____ **Payment Received by:** _____ **Physician #:**_____ **Location Code:**_____

Payment Method: ☐Cash ☐Check #_____ ☐Credit Card #_____ /_____/_____/_____ Exp: _____CVV Code:_____

Name as it Appears on credit Card _____ Zip Code for Credit Card _____
☐Visa ☐Mastercard ☐Discover ☐American Express