



DISABILITY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

What are these forms for?: FMLA ____ Short term disability ____ Spouse ____ Other ____
Continuous leave ____ Intermittent leave ____ Work accommodations ____

There is a **\$25.00 charge per set of forms** for the completion of FMLA and/or disability forms. (Each document that requires your physician's signature is considered a form.) This will be due at the time you drop off or send in your forms.

Please allow 7-10 business days for completion of your form(s).
For a 24-hour turnaround, there will be an additional fee of \$10.00 per form.

1.) Please have **YOUR PORTION** of the forms completed. We cannot complete our portion without your signature. If this form is for someone other than the patient, please list the patient's name and relationship on the form(s) for reference.

2.) What would you like us to do with your form(s) when completed?:

- _____ Please fax form to the number on the paperwork, or to _____ Attn: _____
- _____ Please send it by secure email to: _____
- _____ Please call me to pick up.

Physician: Lindauer ____ Abreu ____ Miller ____ Conway ____ Scott ____ Buchenroth ____ Bowers ____

****Please note we can only give the amount of time that is medically indicated, or otherwise specified by your provider. Vaginal delivery 6 weeks, C-Section 8 weeks. In addition, we can only write spouse/partner for 2 weeks****

I authorize Northwest Obstetrics & Gynecology Associates, Inc. to release any or all of my personal medical information to: _____ for the purpose of completing my paperwork.
(employer or insurance company name)

Signature of Patient

Date

Internal use only: Acct # _____ Number of forms _____
Pt paid \$ _____ Rec'd by _____ Claimed _____