



The Saluda Center
Disability Forms Fee Notice

Patient Name: _____ Patient Date of Birth: _____

Please initial each line.

_____ I understand that in order for me to submit a request to have any short or long term disability form completed, that I must attend 3 consecutive appointments with my provider.

_____ I understand that forms may be completed with 7-14 business days.

_____ I understand that and I will be charged a fee to have these forms completed that could range in the amount of \$25.00 to \$75.00.

_____ I understand that the fees for having forms completed will be collected before forms are given to the provider to complete. Form must be turned in to the administrative office staff. Please don't give forms directly to providers.

Form Fees:

\$25.00: Any forms that are 2 pages and under

\$50.00: Any forms that are 3 to 5 pages

\$75.00: Any forms that are six or more pages

I have read and understand the policy for disability form completion. I will abide by this guideline. If this is not signed by patient, please indicate relationship to patient (ex: parent, Power of Attorney, guardian, etc)

Patient's Name: _____ Date: _____

Signature: _____

Relationship(if applicable): _____

Office Staff Signature: _____ Date: _____

Office Use Only:

_____ Forms up to 2 pages \$25.00 _____ Forms 3-5 pages \$50.00

_____ Forms 6 pages or more \$75.00

Amount Collected \$ _____ Circle One: Debit Visa MC Disc Amex Cash Check# _____

Date Collected: _____ Collected By: _____