FMLA/Disability Cover Sheet

Dear Pacific Women's Center Patients:

As a provider of women's health care, our objective at Pacific Women's Center is to assist our patients and their families with paperwork that is inherent with the delivery of these services.

It is our practice policy that patients who request Pacific Women's Center, LLC to complete paperwork relating to a disability or Family Medical Leave Act (FMLA) will receive one form free of charge. Subsequent requests related to the same medical incident may be subject to a $10.00 fee per form. The fee covers the cost of completion and retention within the patient's medical records. With an ever-increasing number of requests, it will allow us to continue to provide this service to our patients. Please be sure and provide all the necessary information so that the original request may be completed accurately and completely and to help eliminate or limit any fees.

The potential charge is not covered under insurance policies and will need to be paid prior to or upon receipt of the completed paperwork.

Please complete this Disability Form Records Request and provide any employer mandated forms with your request. If it is deemed that a fee must be assessed, you will be notified prior to completing the documents and payment will be due on, or before the documents are delivered.

Today's Date: _____/_____/_____ Follow Up Request (May be subject to a $10.00 fee) ____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Forms Intended For: _____Self _____Spouse/Partner _____Other

Name/Relation: _____Phone: _____

Physician's Name: _____ Circle One: GYN OB

Reason for Leave: _____

Leave Start Date: ____/____/____ Date Returning to Work: ____/____/____ # of Weeks: _____

When Forms Are Completed: Patient would like forms: _____ Faxed _____Mailed_____Will pick up in office

(If applicable) Employer's Name: _____

Employer's Phone: _____ Employer's Fax: _____ Fax Attn: _____

Thank you! **Please allow two weeks to process your request.** **Thank you!**

----------For Office Use Only: ----------

Payment Date: _____ Payment Taken By: _____ Payment Form: Cash Check Credit Card

Initial Request: _____ Followup Request (May be subject to $10 fee): _____