John J. Regan, M.D.

Patient Registration Sheet

Referring Physician: _____

Address: _____

City, State, Zip: _____

Telephone :( )_____

Patient Name: _____
(First, Last)

Home Address: _____
(City, State, Zip)

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell No. / Pager :( ) _____ Fax#: ( ) _____

Date of Birth: _____ / _____ / _____ SSN# _____ - _____ - _____ Sex: ◊ Male ◊ Female

Marital Status: ◊ Married ◊ Single ◊ Widowed ◊ Divorced

Email Address: _____Occupation:_____

Employer Name: _____

Employer Address:_____
(City, State, Zip)

Emergency Contact: _____ Relationship _____

Emergency Contact Telephone# :( ) _____

Complaint: _____

Medicare Number: _____Part A_____ Part B _____Effective Date_____

Primary Insurance: _____ ◊ PPO ◊ POS

Insurance Address: _____

Insurance Telephone: _____ Group#: _____ ID#:_____

Effective Date: _____/_____/_____Coverage Code: _____ Subscriber Name:_____

Policyholder (if patient is NOT the subscriber) DOB: _____/_____/_____ SSN#: _____ -_____ -_____

Secondary Insurance: _____◊ PPO ◊ POS

Insurance Address: _____

Insurance Telephone: _____ Group#: _____ ID#:_____

Effective Date: _____/_____/_____ Coverage Code: _____Subscriber Name: _____

John J. Regan, M.D.

Patient Registration Sheet

Patient History

1. When did symptoms first start?_____

_____

2. Please describe your symptoms (include the type of pain and the body part affected)_____

_____

_____

3. Does a position and/or medication relieve your pain?_____

_____

_____

4. Do you have any pain, numbness, tingling or weakness in your arms or legs? Please describe._____

_____

_____

5. Are you presently working?
   - ☐ Full Time
   - ☐ Part Time
   - ☐ Disable
   - ☐ Retired

6. Please list all tests you have had done and the results (including X-rays, Lab tests, EMG, MRI & CT Scans, Myelogram, Physical Therapy)_____

_____

_____

7. Please list previous treatments given or recommended_____

_____

8. Are you currently receiving treatment for any other medical condition?_____

_____

9. Social History:

   Age:_____ Height:_____ Weight:_____lbs.

   Marital Status: Children:_____
   - ☐ Single
   - ☐ Married
   - ☐ Widowed

   Do you smoke?__no__yes If so, how much?_____

   Alcohol intake?__no__yes If so, how much?_____

10. Describe usually physical activity/exercise.

Type	Frequency	Top	Frequency
1.		4.	
2.		5.	
3.		6.	

John J. Regan, M.D
Patient Registration Sheet

JOHN J. REGAN, M.D. - PAIN DRAWING

PATIENT: _____ AGE: _____ DATE: _____

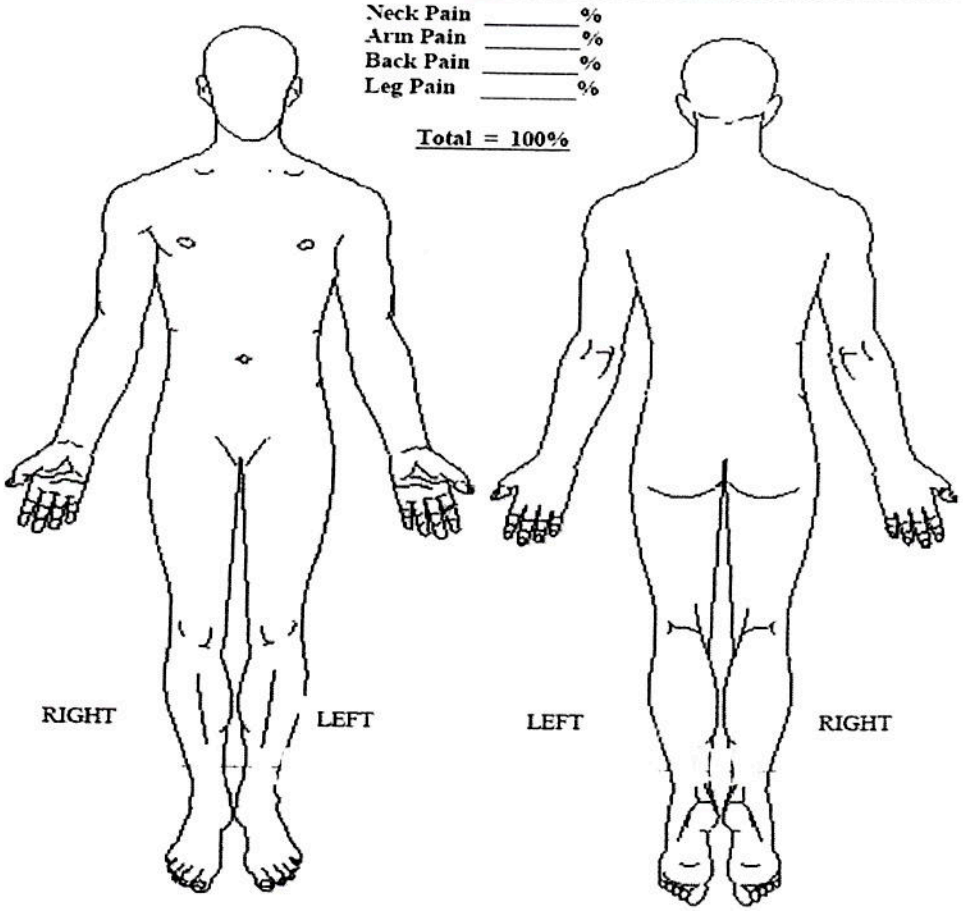
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	RADIATING PAIN
^ ^ ^	O O O	■ ■ ■	X X X	///
^ ^ ^	O O O	■ ■ ■	X X X	///
^ ^ ^	O O O	■ ■ ■	X X X	///

Neck Pain _____%
Arm Pain _____%
Back Pain _____%
Leg Pain _____%

Total = 100%



PLEASE MARK ON THE LINE:

How bad is your pain now?

0 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

NO PAIN — INTERMEDIATE PAIN — WORST PAIN

John J. Regan, M.D.

Patient Registration Sheet

General Review of Systems
Provided to John Regan, MD

Name:_____
Signature:_____

Allergies
- Asthma
- Hay Fever
- Skin eruptions

Cardiovascular
- Chest pain
- Irregular heart beat
- High/low blood pressure
- Poor circulation
- Rapid heart rate
- Swelling of ankles
- Varicose veins

Constitutional
- Chills/sweats/fever
- Fainting
- Forgetfulness
- Heachache
- Loss of sleep
- Nervousness
- Weight loss

Ears, Nose, Mouth, Throat
- Bleeding gums
- Difficulty swallowing
- Earache
- Ear discharge
- Hearing loss
- Hoarseness
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problem

Endocrine
- Rapid Weight loss/gain
- Intolerance to warm room
- Multiple broken bones
- Cessation of menstrual periods
- Excessive hunger/thirst
- Loss of libido
- Spontaneous nipple discharge

Eyes
- Blurred Vision
- Crossed eyes
- Double vision
- Vision flashes or halos

Genitourinary
- Blood in urine
- Lack of bladder control
- Painful urination

Gastrointestinal
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Rectal bleeding
- Stomach pain

Hematologic/Lympathic
- Swollen lymph nodes
- Easy bruising skin
- Prolonged bleeding from cuts, tooth extractions

Integumentary
- Skin rashes or eruptions
- Chronic skin itching

Men
- Breast lump
- Lump in testicle
- Penis discharge
- Sore on penis

Musculosketal
Pain, weakness, numbness or swelling in:
- Hands, wrists, hips, knees, or joints
- Pain in arms or legs

Neurological
- Fainting
- Headaches
- Numbness of arms or legs
- Seizures
- Tingling of hands, feet, arms, or legs

Psychiatric
- Anxiety
- Depression
- Panic attacks
- Restlessness

Respiratory
- Blood
- Cough
- Dizziness
- Shortness of breath

Women
- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse

Date of last period:_____
Date of last pap smear:_____
_____

Mammogram Date: _____
_____

Are you pregnant? _____
No. of children (ages) _____
_____
_____
_____
_____
_____

John J. Regan, M.D.

Patient Registration Sheet

Personal

Name	Last First Middle
Age	Sex Occupation Working/Disabled/Retired Rt. or Lft. Handed
Marital Status	□ Married □ Single □ Divorced □ Separated □ Widowed

Current Problems:

Symptoms:	Duration:

Past Medical History

Previous Operations:	Dates:

Other Past and Current Medical Problems:
(eg. Hypertension, diabetes, asthma, stroke, cancer, etc)

Family History: Parents, grandparents, siblings (alive, if deceased, list cause)

Medications:

Medications: (List all current medications: (including aspirin)

Allergies to medication:

John J. Regan, M.D.

Patient Registration Sheet

Please list any medications you have allergies to :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list doctors you want reports sent to:

Doctor _____ **Practice** _____

Phone Number _____ **Fax Number** _____

Address _____ **Suite** _____

_____

_____

Full Name _____

Date of Birth _____ / _____ / _____

Social Security _____ - _____ - _____

Confidential Phone number ( ) _____

John J. Regan, M.D.

Patient Registration Sheet

WORKERS COMPENSATION INFORMATION (IF APPLICABLE)

Name of Insurance Company:_____

Address: _____

City, State, Zip Code: _____

Name of Adjuster: _____

Telephone Number: _____ext _____Fax Number: _____

Nurse Case Manager: _____

Telephone Number: _____ext_____ Fax Number: _____

Claim Number: _____ Date of Injury: _____

Employer: _____

WCAB Number: _____

OFFICE USE ONLY

New Patient Packet Received on _____

Reviewed by RN on: _____ OK to schedule: _____Other: _____

Appointment Date/Time: _____

Directions to 8750 Wilshire Blvd., Suite 350
From the San Diego Freeway:

- I-5 N to I-10 W. Santa Monica Freeway
- Take Exit 1A toward Santa Monica Blvd.
- Take Exit 7A for Venice Blvd. to La Cienega
- Slight left onto Cadillac Ave.
- Take the first right onto S. La Cienega Blvd.
- Turn left onto Wilshire Blvd., Office will be on the left

John J. Regan, M.D.
Patient Registration Sheet

John J. Regan, M.D.
Spinal Surgery
Diplomat A.B.O.S.

8929 Wilshire Blvd.,
Suite 302
Beverly Hills, CA 90211
Office 310.881.3730
Fax 310.595.1063
www.spinegroupbeverlyhills.com

Medical Records Release Form

I hereby authorize,
Providers Name/Facility:_____

Phone Number:(____)____-____ Fax Number:(____)____-____

Address:_____
City:_____State_____ Zip:_____

Practice:_____

Please release the following medical information regarding my previous healthcare:

- ☐ Physician Progress Notes
- ☐ Diagnostic Reports
- ☐ History & Physical Exam
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Pathology Report
- ☐ MRI, CT Scan, X-Ray Films/CD
- ☐ Full Medical Records
- ☐ Other_____

Patient Name(Print):_____

Signature:_____

Date of Birth:___/___/_____

Date:___/___/_____

John J. Regan, M.D.

Patient Registration Sheet

John J. Regan, M.D.,
Spinal Surgery
Diplomate A.B.O.S

8929 Wilshire Blvd., Suite 302
Beverly Hills, CA 90211
Office 310.881.3730
Fax 310.595.1063
www.spinegroupbeverlyhills.com

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPPA)

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclose of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. of foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institution or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You have the right to request and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to John J. Regan, M.D., 8929 Wilshire Blvd, Suite 302, Beverly Hills, CA. 90211 Telephone: 310.881.3730
3. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the submitted to John J. regan, M.D., 8929 Wilshire Blvd, Suite 302, Beverly Hills, CA90211, Telephone: 310.881.3730 You must provide us with a reason that supports your request for amendment
4. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice, contact our front desk receptionist.
5. Right to file a complaint. If you believe your privacy right has been violated, you may file a complaint with out practice of with the Secretary of the Department of Health and Human Services. To file an complaint with our practice, contact John J. Regan, M.D., 8929 Wilshire Blvd, Suite 302, Beverly Hills, CA. 90211 Telephone: 310.881.3730. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain you written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
7. If you have any regarding this notice or our health information privacy policies, please contact John J. Regan, M.D., 8929 Wilshire Blvd., Suite 302, Beverly Hills, CA. 902111 Telephone: 310.881.3730

John J. Regan, M.D.

Patient Registration Sheet

Notice of Privacy Practices (1996)

This Notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain confidentiality of your health information

I, _____ have read and received the HIPAA notice of
(Print Last, First Name)
Privacy Practices.

_____
Signature

_____
Print Name

Date: _____

John J. Regan
Spinal Surgery
Diplomate A.B.O.S
8929 Wilshire Blvd.,
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Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputed with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services.

_____
Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

SPINE GROUP BEVERLY HILLS _____ _____ _____
Physician's or Authorized Representative's Signature (Date) Patient/Representative's Signature (Date)

John J. Regan, MD
8929 Wilshire Blvd, Suite 302
Beverly Hills, CA 90211
Print or Stamp Name of Physician,

By: _____
Print Patient's Name

Medical Group or Association Name

_____
(If Representative Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records

John J. Regan, MD
8929 Wilshire Blvd, Suite 302
Beverly Hills, CA 90211

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The Office may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by fax or e-mail.

A. Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment

Your protected health information will be used, as needed to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the imaging studies. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations

We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the office and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures

As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your appointment date, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted regarding fund-raising, please contact our Privacy Officer. As a method of contacting the patient, we may also leave a message on your answering machine or voice mail to discuss pertinent issues.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required

We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health

We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspended Abuse, Neglect or Domestic Violence

We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes

We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation

We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes

We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety

We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

John J. Regan, M.D.

8929 Wilshire Blvd., Suite 302
Beverly Hills, CA 90211
Office 310.881.3730
Fax 310.595.1063

Fees For Form Completion / Administration Services

Insurance Health Plans DO NOT pay for all of your Health Care needs.

They pay for recovered items and services when their rules are met. We have found the need to inform you that the services below are not covered.

Pre-Printed RCSM form requiring

• A check mark only	no charge
• Another document	$25.00

Copy of part or all of Chart

• 10 – 50 pages	$15.00
• Each additional page	$0.25

Dictated Letters or Reports	$100.00
Special Forms	
*Disability Forms	$30.00
Prescription Authorization forms	$20.00
Disability Parking Placard form	$20.00
No flying Letter	$30.00
Off Work Letter	$30.00

Note: Patients **MUST** pay above fees before form is processed.

Your signature below states that you understand this policy.

Signature: _____ **Date:** _____