Plumtree Family Health Center

FORM COMPLETION REQUEST

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Number of pages:_____

Date of drop off: _____ Requested date of completion: _____

1. Please make sure ALL of the patient sections are completed. This includes important dates and answering patient specific questions. Forms without all the necessary information will be returned and delay the completion of the form. Ensure your full name is on each page.
2. It is recommended that you keep a blank copy of the form for your records.
3. **We will do our best to have the form completed by your requested date but please know that it is not a guarantee that it will be completed by the date requested above.**
4. There may be a fee to complete any form. A minimum fee of $20.00 is charged to the patient for completed of forms other than those used in our office. The fee charged is determined based on the complexity of the form. **We only accept CASH for form fees.** This will be determined by your Provider. **Explanation of fees for completion of forms:** The Providers receive multiple requests everyday to complete forms for patients. A majority require the Provider to review the patient's record and determine the information needed. These are services not covered by our routine visit charges.
5. **If you would like the form faxed or mailed after completion, payment will be required prior to faxing or mailing. You can pay the minimum form fee of $20.00; We can refund your fee if there are any problems with completion of the form.**

Patient Signature: _____ Date: _____

Please include any other important information that may help us when completing your form.

_____

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FOR INTERNAL USE ONLY

Accepted by: _____ Reviewed by\ Documented by: _____ Provider: _____

Date Given to Provider: _____ Date Completed: _____

Scanned by: _____ Patient Informed of Completion: _____

Date of Pick up: _____ 20.00 Fee Form Collected by: _____

Notes: _____

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