



INSURANCE AND DISABILITY RELEASE FORM

Forms submitted for completion by our office **must have all** patient information sections completed and signed **prior to submission**.

Any and all forms with the exception of industrial work status will be subject to a fee which must be paid at the time the form is presented. The fee will apply to each set of forms submitted. The fees are \$15 for one page forms and for more complex forms 2 or more pages and FMLA forms are \$30. Please allow 7 to 10 business days for completion.

PLEASE PRINT and COMPLETE prior to presenting to the office staff

Patient Name: _____ Today's Date: _____

Physician Name: _____ Treating Office: **Avondale or Peoria**

First Date you were *unable* to work: _____

Have you been released to work? **Yes** (date released) _____ **No** _____

Indicate ONE of three methods in which the form(s) can be submitted:

Call me when the form is completed _____ Phone # _____

Fax directly to the insurance company: _____ Fax # _____

In attention to: _____ Phone# _____

Mail directly to the insurance company _____ Attn: _____

Address: _____

Patient Signature

This Section if for office use only: Patient's Account# _____

Number of pages _____ Total Paid \$ _____ Cash / Check / Credit Card

Form received by: _____ Credit Card: Visa / MC

Type of Form: DISABILITY FMLA OTHER:

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