Delaware Neurosurgical Group, PA

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## Disability Form Completion Policy

Due to a high volume of disability paperwork submitted daily, we have instituted the following policy. Please read the policy thoroughly and sign below to acknowledge you have read and understand our policy.

1. Charges
    a. The fee to complete each form is $15.00.
    b. This fee must be paid prior to the completion of the form.
    c. Please submit this payment at the time you submit your request, to avoid delaying the processing time of your form.
2. Time
    a. All forms are completed in the order in which they are received.
    b. All forms will take up to **10 business days** from the date it is received to be completed.
    c. **Please plan accordingly.** All requests will be date-stamped upon receipt.
3. Required Information
    a. Forms cannot be completed until your most recent office note has been transcribed. This may increase the time to process the form.
    b. All patient information must be completed prior to submitting to the office.
    c. If you would like your form to be faxed, please provide the fax number.
4. Completed Forms
    a. All completed forms will be mailed to your home address.
    b. If you requested your form to be faxed, a copy will also be mailed to your home address.
    c. If another facility or office requires a copy of the completed form, it is your responsibility to send to that party.
5. Messages Regarding Status of Forms
    a. Please understand there is an immense amount of forms submitted to our office for completion, it will take up to 10 business days to complete the form.
    b. We ask that you avoid inquiring about the status of the form prior to the 10 business days' time frame. We continuously complete forms in the order they are received.
    c. We will mail and/or fax your form as soon as it is completed. If there is a problem during completion, we will contact you.

*Our goal is to provide optimal patient care. Your thorough understanding of our policy will help us continue to do this. Thank you for your cooperation.*

☐ I have read and understand and agree to comply with the Disability Form Completion Policy.

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Patient Signature Date