FORMS POLICY - FMLA, SHORT-TERM & LONG-TERM DISABILITY

The physicians of Medical Associates will provide an excuse due to medical illness with specified dates at no charge during a clinic visit. If further information is requested such as FMLA, SHORT-TERM DISABILITY, or LONG-TERM DISABILITY forms, a consultation visit must be scheduled with the physician but only **AFTER** all of the necessary information is obtained. **The charge for the consultation visit is $85.00. It is not billable to insurance and therefore must be paid in full prior to your visit.**

Prior to your visit being scheduled:

- Review and fill out this form. **(FORMS POLICY-FMLA, SHORT-TERM & LONG-TERM DISABILITY)**
- Review the **DEFINITIONS** page thoroughly.
- Fill out the **QUESTIONAIRE** completely.
- Fill out the patient portion or **YOUR FORM.**

❖ The **QUESTIONNAIRE** and the **patient portion** of **YOUR FORM** must be filled out prior to scheduling your consultation.

❖ Please note that any forms we receive without a completed **QUESTIONNAIRE** or incomplete sections to be filled out by you the patient will be mailed back to you at your expense.

*If you need or your form requires a **physical capacity examination** (PCE), you must bring the results of this exam to your consultation visit.*

- Please note: **WE DO NOT DO PHYSICAL CAPACITY EXAMINATIONS**.
- These PCEs are typically 4-5 hour examinations that are somewhat costly and usually not billable to insurance.

Once you complete the above, you may mail them in or bring them in for a consultation visit to be scheduled. The consultation visit will consist of reviewing the forms with the physician and making any necessary corrections.

FAMILY MEDICAL LEAVE ACT (FMLA) & DISABILITY EXAMINATION

Do you have a condition that qualifies as a "serious medical condition" under FMLA? Examples that would not qualify are the common cold, sinusitis, bronchitis, headaches, back pain, and other similar conditions do not qualify. Examples that may qualify are: major surgery, chemotherapy, and hospitalization as a result of incapacity and/or regimen of continuing treatment. PLEASE REVIEW **DEFINITIONS PAGE** & CHECK THE CATEGORY THAT BEST DESCRIBES YOUR CONDITION.

☐ **HOSPITALIZATION**

☐ **WORK ABSENCE + 4 OR MORE DAYS**

☐ **INTERMITTENT (SPORADIC) INCAPACITY DUE TO CHRONIC CONDITION(S)**

☐ **PERMANENT (LONG-TERM) INCAPACITY DUE PERMANENT UNIMPROVING PROGNOSIS**

☐ **INCAPACITY DUE TO MULTIPLE TREATMENTS FOR SEVERE CONDITION**

PATIENT'S NAME (PRINT):_____

ADDRESS:_____

PHONE #:_____**DATE OF BIRTH:**_____

I hereby authorize Medical Associates of the Shoals to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer protected by this rule. I am requesting that the protected information be released to the following parties:

SIGNATURE:_____**DATE:**_____

NAME OF INDIVIDUAL OR COMPANY:_____

ADDRESS:_____