

Jonathan Saunders, MD, FACS Katheryn Warren, MD, FACS Julia MacRae, MD

DISABILITY FORM COMPLETION

In order to ensure a smooth process we ask that you answer all of the below questions and allow a least **TWO (2) WEEKS** for completion of the forms.

Please note that there is a \$25.00 fee for the first form, and \$15.00 for each additional form.

This fee must be paid at the time the forms are submitted.

Name	DOB
[]]	Jonathan Saunders, MD [] Katheryn Warren, MD [] Julia MacRae [] Dakota Urban
Do yo	ou want your form(s) (check all that apply):
()	Faxed to Attn: Fax Number: ()
()	Mailed to:
()	Emailed to:
()	Forms to be picked up by:
Other Reque	instructions: week(s) month(s)
I unde health author	al time off is determined and approved by the insured's employer and/or insurance company.) erstand Christiana Cosmetic Surgery Consultants is authorized by me to use or disclosure my protected information for a purpose other than treatment, payment, or health care operations. I have read this ization and understand what information will be used or disclosed, who may use and disclose the nation, and the recipient(s) of that information.
Signa	Drop off dateture
Paym	ent [] Cash [] Check # [] Credit card [] Money order
Date 1	Paid: