CHRISTIANA
cosmetic surgery consultants

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 **$20.00** fee for this service.
****This fee must be paid at the time the forms are dropped off at the office****

Name _____ DOB _____

[ ] Jonathan Saunders, MD [ ] Katheryn Warren, MD [ ] Julia MacRae

Do you want your form(s) *(check all that apply)*:

( ) Faxed to Attn: _____ Fax Number: (____)_____

( ) Mailed to: _____

_____

( ) Forms to be picked up by: _____

Date of Surgery: _____

Other instructions: _____

Requested amount of time off: _____ week(s) _____ month(s)
(Actual time off is determined and approved by the insured's employer and/or insurance company.)

I understand Christiana Cosmetic Surgery Consultants is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.

_____ Drop off date _____
Signature

Payment [ ] Cash [ ] Check #_____ [ ] Credit card [ ] Money order

Date Paid _____