FORM COMPLETION

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>Medical Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLIES TO</td>
<td>Patients</td>
</tr>
<tr>
<td>EFFECTIVE DATE</td>
<td>01/01/2016</td>
</tr>
</tbody>
</table>

PURPOSE

The purpose of this policy is to ensure that all forms are completed in a timely manner and appropriate procedures are followed in the processing of forms.

INFORMATION AND PROCEDURES

Form: any documentation that has to be completed with medical information and requires a provider's signature.

These may include but are not limited to

- Family Medical Leave Act (FMLA)
- Disability Determination
- Insurance Requests
- Auto Requests
- Workers Compensation Requests
- Other

Processing Time: 7 to 10 business days, they will be completed in the order they are received.

How to Submit for Completion: forms may be dropped off at either of our locations, or mailed to the downtown office (350 Lafayette Ave). If forms are mailed payment must be included.

- Please note that clinicians are not able to take forms in patient rooms; please turn them in at registration or the 5th floor business office for completion.
- A cover sheet must be completed with all information necessary to process form; these are available on our website, registration, and 5th floor downtown business office.

Charges: Charges will be entered upon receipt of blank form. All charges for form completion unless Auto or Workers Compensation must be paid for before forms will be completed

<table>
<thead>
<tr>
<th>Type of Form</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>$25</td>
</tr>
<tr>
<td>Auto/Letter Request</td>
<td>$75</td>
</tr>
</tbody>
</table>

Completed Forms: once forms have been completed they will be returned to patient/designated location either by faxing, mailing, or patient picking them up.
Disability/FMLA Form Request

We are pleased to assist you in completing your Disability and FMLA forms. Be advised there will be a 10 business day processing time frame, as well as a processing fee based on the type of form.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however all paperwork will be processed in the order that we receive it without exception. If you would like a copy of the form for yourself, please contact RVO directly at 616-456-8515.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

*Indicates Required Field

*Patient’s Name (First, Middle Initial, Last)________________________________________________________________________

*Date of Birth _____________________  *Preferred Daytime Phone Number ________________________________

OK to Leave a Detailed Phone Message? □ Yes □ No  *E-Mail Address ________________________________

*Email address will be used to provide status updates

□ Disability forms ($25)                  □ FMLA Forms ($25)                      □ Auto/Work Comp (bill)

Date of Injury: ___________________________  First Day Unable To Work: ____________________________

Length of expected leave:__________________

*Name of company or employer to receive form:

Name:_______________________________________________________

Address:____________________________________________________________________________________

Fax:__________________________________________________________

***Attach this form to the document to be completed for disability determination

I authorize River Valley Orthopedics to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I also acknowledge I am responsible to pay the form completion fee prior to form completion.

Signature: _____________________________________ Last 4 digits of your SS# __________

TO BE COMPLETED BY OFFICE STAFF

□ Payment collected

□ I approve this form completion  Provider/Desigee Signature