

Form Completion Questionnaire

If you are leaving a form with our office that needs to be completed for insurance, work, FMLA or other reasons, we ask that you complete the following questions with specific and complete responses, so that we can complete your form in an accurate manner and not have further delays. If we are not able to complete the form with the information provided below, you may be asked to schedule an appointment. This will allow us to gather the appropriate information and documentation for your chart and for the completion of this form.

**A fee of \$10.00 per form is to be paid when the form is dropped off at Holm Medical Clinic.
The form will not be completed until this fee has been paid.**

Patient Name: _____ **Date of Birth:** _____

Date Time Phone: _____ **Patient's Provider:** _____

Please advise if form is being completed by someone other than the patient: _____

What illness/injury is this form regarding? _____

When did this illness/injury begin and end? _____

What are the dates you were required to be off work? _____

List any other Healthcare providers you are seeing or therapy you are having for this illness/injury?

I authorize Holm Medical Clinic to fax my form to:

_____ (company) _____ (Fax number)

You will be called upon completion, which may take up to 14 days to complete.

Signature

Date

Office Use Only:

Fee Paid: \$ _____

Comments:

