CHECKLIST FOR ALL FORMS

****UP TO 10 BUSINESS DAYS IS NECESSARY TO COMPLETE ALL PAPERWORK****

Initial Form Fee: $25.00 **Follow-Up Form Fee: $10.00**

PATIENT

- VOA Physician/Mid-Level: _____
- Date last worked: _____Type of Form: _____
- They plan to continue to (check box):

  ☐ Work intermittently ☐ Not work
- The form is for family member (name): _____
- Name of the patient: _____ DOB: _____
- Patient phone #: _____
- The form is to:

  Mail (if fee is paid in-advance)
  Address: _____

  City: _____ State:_____ Zip Code: _____

  Faxed (if fee is paid in-advance)
  Fax Number: _____

  Patient will pick up at front desk:
  Contact Number: _____

I acknowledge that I have read and completed the above information and recognize the 10 day completion requirement.

Patient Signature: _____ Date: _____

VOA STAFF ONLY **Patient MR#** _____

❑ The patient has completed their portion of the form in its entirety and signed their consent for us to release the requested information

❑ The designated office staff has completed the VOA demographics section

❑ Date due back to designated staff: _____ Date of next scheduled appointment:_____

❑ All pages of the form are clipped together (no missing pages) with this form on front

Initial Form _____ Follow-Up Form _____

Paid In-Advance _____ Pay at Pick-up _____

VOA Staff Member Name: _____
(Print)

Virginia Oncology Associates