

# 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)

