BLUEWATER BEHAVIORAL HEALTH

4400 East Highway 20, Suite #313, Niceville, FL 32578* Phone (850) 797-2598 * Fax (850) 807-5127

NOTICE OF CHARGE FOR COMPLETION OF FORMS

We require payment for completing forms on your behalf. We receive numerous requests for completion of forms, including disability, FMLA and workers comp. This requires extra work, time and financial resources in excess of the normal requirements to complete the medical record.

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. We will make every effort to complete these forms within 7-10 business days after payment. We cannot make any assurance of completion within your time frame.

PAYMENT IS REQUIRE PRIOR TO COMPLETION OF THE FORM(S).

Instructions:

- Payment of $100.00 is required prior to completion of the form(s).
- We are not obligated to complete these forms, but do so as a courtesy to you. We reserve the right to refuse to complete any forms you present to use for completion. In general, providers do not complete forms for patients seen regularly for less than 6 months to allow time for proper assessment.
- Please make sure all of your information is completed on the form before you turn in.
- Do not complete the sections of the form to be completed by our office.

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.

Patient Name: _____ DOB: _____

Preferred Daytime Phone Number: _____

OK to Leave a Detailed Message? YES / NO

Email Address (to provide status updates): _____

Form to Be Completed: _____

Notes to Provider for completion (optional): _____

_____

_____

Name of Company or Employer to Receive Form: _____

Address: _____

_____

Fax Number: _____

I authorize Bluewater Behavioral Health, Inc. to provide charts, records, notes, x-rays, lab and medication records and all other medical/psychiatric information about me, including medical history, psychiatric history, diagnoses, testing, test results, prognosis and treatment of any physical or mental health 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, earning or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claim status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

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

Patient Signature: _____ DOB: _____

TO BE COMPLETED BY OFFICE STAFF:

_____ Date form received

_____ Date payment collected

_____ Approval of form completion by provider