ARIZONA ARRHYTHMIA CONSULTANTS

Acknowledgement of Fee Schedule For Provider-Completed Forms

Arizona Arrhythmia Consultants charges an administrative fee for certain work or insurance related documents presented by patients for completion by its providers. These documents include disability insurance benefit forms and Family and Medical Leave Act (FMLA) forms. Typically, your employer or insurance company will require these forms when seeking leave because of a medical condition that prevents you from reporting for work. A licensed medical professional must complete and sign these documents certifying that the medical information is correct.

We will be happy to assist you by completing the provider section(s) of these forms. The fee for this service is $35 per document for all new benefit claims and $25 per document for any follow-up paperwork. Copies of medical records for disability claims are provided to the disability company at no charge to the patient. These fees are due *prior* to the completion or the forms.

Our priority is providing treatment to our patients; therefore, we ask that you give us a minimum of ten business days for completion of forms.

Please follow these steps to ensure the successful and timely completion of your forms:

1. Obtain a copy of the required forms from your employer or insurance company. These forms are also available from the Wage and Hour Division of the U.S. Department of Labor:
    a. http://www.dol.gov.whd/forms/wh-380-e.pdf (for Employees)
    b. http://www.dol.gov/whd/forms/wh-380-f.pdf (for Family Members)
2. Complete all parts of the form that are to be completed by the employee.
3. Mail or drop off the form(s) at our main office. Remember to include a check payable to “Arizona Arrhythmia Consultants”.
   Our address is: **Arizona Arrhythmia Consultants**
   3225 N Civic Center Plaza, Suite 1
   Scottsdale, Arizona 85251
4. Please allow 10 business days for completion.
5. Please remember, the forms will be completed after we receive your payment. We encourage you to submit the forms as soon as possible.

I acknowledge that I have been advised of the above-stated fees.

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Signature Date

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Patient Name Relationship to Patient
(If signature of Personal Representative)