

## Neurology Center of Fairfax

3020 Hamaker Court, Suite 400

Fairfax VA 22031

### If You Need NCF To Complete Disability Forms or Write a Letter on Your Behalf...

NCF understands the importance of disability forms to our patients. Please read this carefully to understand what you can expect and what information is needed from you.

#### Turnaround Time

Please provide us with as much advance time as possible when you need us to complete disability forms. To be done properly the process takes time at least a week. If your request involves records in outside storage, it can take longer. **We regret that we are unable to complete the process on short notice.**

#### What Is Needed From You

To complete your request accurately and promptly, these things are required **each time** you need a disability form completed.

1. Provide a **copy of the specific form** needed. Please be sure you have filled out the portions required of you, and that you have signed the request.
2. Specify what **issues** are important. Please provide a written note of those issues that you or your employer consider important in the disability determination.
3. Complete the **Work Capacity form**. The doctor needs answers to those specific questions. Please be prepared to complete this form each time you request us to complete a disability form. Without the Work Capacity form we are not able to complete your disability forms.
4. Include an **NCF release** signed by the patient. By law you must authorize us in writing to provide this information. Verbal authorizations are not sufficient. Only the patient may authorize the release of information, unless you hold a formal legal power of attorney.
5. There is a **fee** for each form. Fees for common disability forms are: FMLA \$25; most work disability forms \$40. Longer forms and forms with letters start at \$60, but can be higher. MVA forms are done at no charge at office visits only. Please be prepared to pay any fee in advance. This expedites the process and also keeps your costs down. (Some disability insurance carriers will reimburse you for the fee. Some will not.)

#### Other Important Information

1. You may need an appointment. If you have not been seen recently or if your form contains a work evaluation section, the doctor may need you to come in for an appointment before filling out the form.
2. Medical records requests are handled separately. Please see our information sheet on medical records.

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### Patient authorization and request to send protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Patient Address:

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

#### Authorization

By signing this authorization, I authorize Neurology Center of Fairfax, Ltd. To use and/or disclose certain protected health information (PHI) about me

To: \_\_\_\_\_  
Physician or person to receive this information

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This authorization permits Neurology Center of Fairfax, Ltd. To use and/or disclose the following information about me:

#### Time period for records:

From: \_\_\_\_\_ To: \_\_\_\_\_

#### Circle all that apply:

Office Notes      MRA      EMG      EEG      MRI      CAT scan

Laboratory Tests      Letter      Forms      Insurance Information      Billing Statements

Please send the records requested above to the following address:

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

The information will be used or disclosed for the following purpose: \_\_\_\_\_

This authorization will automatically expire 1 year from date signed unless other wise indicated: \_\_\_\_\_  
Expiration date

When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by federal HIPPA privacy rules. I have the right to revoke this authorization in writing. My written revocation must be submitted to the Privacy office at the address for Neurology Center of Fairfax listed above.

\_\_\_\_\_  
Signature of Patient or Legal Guardian\*

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date

\* If legal Guardian, a copy of Power of Attorney is required with this request.

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**Disability/Work Capacity Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date Symptoms Began: \_\_\_\_\_

Date of Diagnosis Made: \_\_\_\_\_

Date Disability Began: \_\_\_\_\_

Diagnosis for Disability: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Last Day Worked: \_\_\_\_\_

If working part – time, date begun: \_\_\_\_\_  
(Hours/Days, or Days/Week)

Current work restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Employer/Job title: \_\_\_\_\_

If you are not currently working, who certified work disability? \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_

Short Term: \_\_\_\_\_ Long Term: \_\_\_\_\_

Why are you disabled? \_\_\_\_\_  
(What can you not do?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What aspects of your job can you not perform? : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_

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List cognitive/ memory problems: \_\_\_\_\_

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Extra:

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Signature \_\_\_\_\_