



State Disability Release Form (EDD)

You or your insurance company has requested a disability form to be completed. Bactes has been contracted by Corona Temecula Orthopaedics 341 Magnolia Avenue Suite 101 Corona, Ca 92879 to process your forms. **A processing fee of \$30.00 for each new state disability form and \$15.00 for each supplemental/extension form is required.** This payment is the responsibility of the patient and needs to be paid in full before completion of your form.

NO CASH PAYMENTS are accepted. Credit card, Check, or Money order only.

Please make checks/money order payable to BACTES

ALL FORMS MUST BE RETURNED TO CORONA ORTHOPAEDIC'S OFFICE

Patient Information	
Patient Name:	DOB:
Address:	
Phone:	Email:
Doctor who is currently treating you:	
Where do you want the form to be sent to after completion? *PRINT LEGIBLY*	
Company name: EDD	
Receipt number:	
Disability information:	
Has the doctor released you back to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dates you were out of work:	to
Date released back to work:	
Work restrictions/comments:	
<p>I authorize Corona-Temecula Orthopaedic Associates to release my Protected Health Information as indicated above. This authorization covers the release of medical records to supplement my disability claim. I understand that:</p> <ul style="list-style-type: none"> My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. **EXPIRES 1 YEAR FROM DATE SIGNED** 	
Signature:	Date:

Any questions please call the Disability Desk at 951-735-6060

Please allow 7-10 business days for processing

CREDIT CARD FORM

Credit Card Payment

_____ *I authorize Bactes to charge my credit card for the amount stated below.*

(Please Initial)

_____ (_____/_____)

Credit Card Number

Expiration Date

Card Type (Circle one) VISA MASTERCARD AMEX OTHER: _____

\$ _____

Amount to Charge Account

X _____

Signature of Cardholder

Name on Credit Card (Please Print)

Billing Address of Cardholder

City, State, Zip Code

(Please do not write below this line, for Bactes Use Only)

Field Request ID