



CENTER FOR
NEURO AND SPINE

762 S. Cleveland-Massillon Rd.
Akron, Ohio 44333
(330) 665-4100

Center for Neuro and Spine
2014
Medical Records & Disability Forms
Request for Payment

Date of request: _____

Patient's First Name: _____ Patient's Last Name: _____

Patient's D.O.B. : _____

Requesting Party:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Services & Fees *(please check which service(s) you are requesting):*

FMLA Forms \$25.00 *(per form)*

Disability Forms \$25.00 *(per form)*

Copy of Records *(99081)* # of pages: _____ Total Amt. Due: \$_____.____

CNS Terms

- All services require payment five working days in advance.
- Upon receipt of this form and your payment, CNS will provide the above selected services.
- Copy of Records charge is based on current year's accordance with Ohio Revised Code Section 3701.742

Date Services Needed By: _____ Total amount due to CNS: \$_____.00

I agree to the above service fees and terms: *Signature:* _____

Please make checks payable to: Center for Neuro and Spine