Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Insurance Verification Form

Date ___________________________

Patient Name ____ DOB ___________________________

Ordering Physician ____ Person # _______________________

☐ CT ☐ MRI ____

Diagnosis ____

Attorney ☐ YES ☐ NO

Name ____ Phone #________________________

Work Comp ☐ YES ☐ NO

Work Comp Carrier ____ Date of Injury ___________________

The above information is correct to the best of my knowledge, and I consent to such diagnostic procedure deemed necessary by my physician for my treatment.

I understand that the staff will contact my insurance company to verify coverage and obtain an authorization if required. This does NOT confirm eligibility for coverage or payment, nor does it assume coverage under my benefit plan. I am responsible for any charges incurred for my MRI/CT that my insurance company does not cover. Musculoskeletal Institute of Louisiana will file my insurance when appropriate, but I will ultimately be responsible for all balances.

____ _______________________________

Patient Signature Date

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Dear Patient:

Musculoskeletal Institute of Louisiana is pleased to provide you with information regarding cost, quality and ease of access, so you can make an informed decision regarding your MRI/CT. Below you will find a list of facilities in which you may have your MRI/CT performed. The Federal Government (Patient Protection and Affordable Healthcare Act, Sections 6409 and 6003, dated March 23, 2010) mandates we provide information on facilities, other than those owned by our physicians. You have the right to choose your facility.

Our physicians work very closely with our technologists on exam protocols to provide the highest quality images. We also take pride in providing services that are easy to access and convenient for the patient.

We would like to thank you for allowing us the opportunity to participate in your care. Our goal at Musculoskeletal Institute of Louisiana is to provide excellence in Ortho/Spine/Neuro services throughout the Ark-La-Tex.

Sincerely,
The Physicians and Staff of Musculoskeletal Institute of Louisiana

Medical Facilities Providing Radiology Services In This Area

Northwest Imaging – 1460 E. Bert Kouns Shreveport, LA 318-425-1001
Services Include: MRI

Ashley Ridge Imaging – 463 Ashley Ridge Blvd Ste. 200 Shreveport, LA 318-869-4747
Services Include: MRI and Ultrasound

Advanced Diagnostics – 855 Pierremont Rd Ste 105 Shreveport, LA 318-861-7413
Services Include: MRI

Willis Knighton and Medical Center – All Radiology services provided.

Christus Schumpert Medical Ctr/Highland Hospital – All Radiology services provided.

I have read and understand the information as stated above. I have been given the opportunity to ask questions regarding any information on these forms.

____ __________________

Patient Signature Date

5/24/22

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Cancellation/No Show Policy for MRI/CT Appointments

Our goal is to provide quality imaging in a timely manner. In order to do so we have a No Show/Late Cancellation policy. This policy enables us to better utilize appointments for all our patients' imaging needs.

IF YOU ARE MORE THAN 10 MINUTES LATE CHECKING IN FOR YOUR MRI, FOR ANY REASON, YOU WILL BE RESCHEDULED. YOU WILL NEED TO USE THE RESTROOM PRIOR TO CHECKING IN.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call 318-629-5433 promptly if you are unable to attend your appointment. If it is necessary to cancel your appointment, we **require** that you call by **2:00pm** one (1) business day in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

Late Cancellation

Cancellations not made by 2:00pm one (1) business day in advance will be considered a "No Show".

No Show Policy

A "no show" is someone who misses an appointment without canceling it by 2:00pm one (1) working day in advance. There is a $50.00 no show/late cancellation fee PER EXAM. Insurance will not cover charges for no show/late fee cancellation fees. You will receive a Televox automated reminder call the night before your MRI/CT. It will ask if you are coming to your appointment. Even if you answer "NO" to the call, this does NOT count as a valid cancellation for your appointment, You MUST call by 2:00pm one (1) business day PRIOR to your scheduled appointment to cancel.

I have read and fully understand all the above information and have been given an opportunity to ask questions.

____ ________________

Patient Signature Date

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MRI Safety Screening/ Consent Form

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI environment if you have any question regarding an implant, device, or object. Consult the MRI Technologists BEFORE entering the room. The **MRI MAGNET** is **ALWAYS ON!!!!**

Name ______________________________ DOB______________ Weight____________

☐ Male ☐ Female Body part to be examined______________________________

Reason for MRI/Symptoms______________________________

Ordering Physician______________________________

Previous neck, back, or brain surgery? ☐ Yes ☐ No

List **ALL** surgeries______________________________

____

Is there a possibility you could be pregnant? ☐ Yes ☐ No Last Menstrual Cycle ______________________________

Are you **CLAUSTROPHOBIC?** ☐ Yes ☐ No Will you be taking a sedative for your MRI? ☐ Yes ☐ No

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Please indicate if you have/had any of the following?

☐ **CARDIAC PACEMAKER**
☐ IMPLANTED Cardiac Defibrillator
☐ Cardiac Stents/Heart valve replacement
☐ IUD/Diaphragm
☐ Joint Replacements
☐ Dentures or Partials
☐ Tissue Expanders (ex. Breast)
☐ Body Piercings
☐ Breathing Problems or motion disorder
☐ Medication Patch
☐ Any type of Prosthesis (Eye, Penile, etc.)

☐ **ANEURYSM CLIP(S)**
☐ Infusion Pain Pump
☐ Hearing Aids
☐ Electrodes or Implanted Devices
☐ Neurostimulators /TNS Units
☐ Insulin or Infusion Pump
☐ Wire Mesh Implants
☐ Tattoo or Permanent Makeup
☐ Ear/Cochlear Implants or Tubes
☐ Shunt/Codman Shunt
☐ Cancer—What Kind______________________________

Have you ever worked as a welder or machinist, or worked with sheet metal? ☐ Yes ☐ NO

Have you ever had an MRI? ☐ Yes ☐ No, If so where? ______________________________

In the event of a medical emergency while in the MRI suite, our in house physician will be contacted. After thorough examination if out physician deems necessary we will call EMS. If you don't want to be transported to the hospital for further evaluation, we reserve the right to terminate the exam and reschedule to a later date. I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have the opportunity to ask questions regarding the information of this form.

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Tech Signature Date

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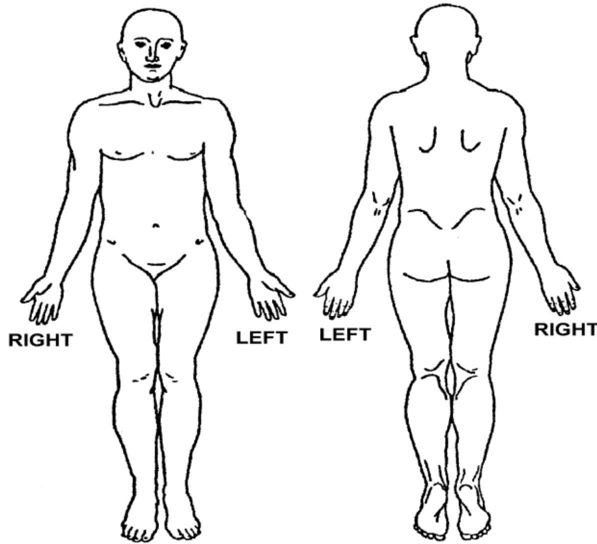
Name ____ **DOB** _______________ **Date**_______________

Please mark on the figure(s) below the location of your pain on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

Patient History

What is your main complaint today? ____

What do you think caused your problem? ____

Have you had surgery in relation to your problem today? ☐ Yes ☐ No

Do you have numbness or weakness? ☐ Yes ☐ No Where? ______________________________________

NOTE: You may be advised or required to wear earplugs during the MR procedure to prevent possible problems or hazards related to acoustic noise.