



A1 MEDICAL IMAGING

A Consolidated Healthcare Company

YOUR APPOINTMENT

Date: _____ Time: _____

A1 Imaging of Ocala

301 SE 17th Street, Ste 102
Ocala, FL 34471
Ph: (352) 622-7459
Fax: (352) 622-9238

A1 Imaging of Kissimmee

810 N. John Young Parkway
Kissimmee, FL 34741
Ph: (407) 847-6745
Fax: (407) 847-8749

A1 Imaging of Ocoee

9450 West Colonial Drive
Ocoee, FL 34761
Ph: (407) 822-0999
Fax: (407) 822-0990

PATIENT INFORMATION

Patient Name: _____ SS No.: _____

DOB: _____ Home Tel.: _____ Work Tel.: _____ Cell: _____

Patient Address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Tel. No.: _____

ID No.: _____ Group No.: _____ Auth. No.: _____

Secondary Insurance: _____ Tel. No.: _____

ID No.: _____ Group No.: _____ Auth. No.: _____

Auto Insurance Name: _____ Tel. No.: _____

Policy No.: _____ Claim No.: _____ Date of Accident: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Tel.: _____

Tax ID: _____ NPI: _____ Contact: _____ Fax: _____

STAT- Call with Report Fax Report Send CD with Patient Send Films with Patient

Diagnosis and Special Instructions: _____

The patient has a "emergency medical condition" (EMC) as defined in Florida Motor Vehicle No-Fault Law, Florida Statutes Sections 627.730-627.7405.

Please determine if the patient has an "emergency medical condition" (EMC) as defined by the Florida Motor Vehicle No-Fault Law, Florida Statutes Sections 627.730-627.7405, and if the Patient does have an "emergency medical condition", then please indicate on your Report. Attached is relevant Patient history.

Physician's Signature: _____ Date: _____

MRI / MRA PROCEDURE

HEAD / SPINE			MUSCULOSKELETAL		
	WITHOUT CONTRAST	WITH CONTRAST		WITHOUT CONTRAST	
Brain	<input type="checkbox"/> 70551	<input type="checkbox"/> 70553	Shoulder	73221	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
IAC's		<input type="checkbox"/> 70553	Elbow	73221	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Pituitary		<input type="checkbox"/> 70553	Wrist	73221	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Orbits	<input type="checkbox"/> 70540	<input type="checkbox"/> 70543	Hand	73218	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Cervical Spine	<input type="checkbox"/> 72141	<input type="checkbox"/> 72156	Hip	73721	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Thoracic Spine	<input type="checkbox"/> 72146	<input type="checkbox"/> 72157	Femur	73718	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Lumbar Spine	<input type="checkbox"/> 72148	<input type="checkbox"/> 72158	Knee	73721	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
BODY			Lower Leg	73718	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
	WITHOUT CONTRAST	WITH CONTRAST	Ankle	73721	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Neck / Soft Tissue	<input type="checkbox"/> 70540	<input type="checkbox"/> 70543	Foot	73718	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
Brachial Plexus	<input type="checkbox"/> 73218	<input type="checkbox"/> 73220	MR ANGIOGRAM		
Chest	<input type="checkbox"/> 71550	<input type="checkbox"/> 71552		WITHOUT CONTRAST	WITH CONTRAST
Abdomen	<input type="checkbox"/> 74181	<input type="checkbox"/> 74183	MRA Head/COW	<input type="checkbox"/> 70544	<input type="checkbox"/> 70546
Pelvis	<input type="checkbox"/> 72195	<input type="checkbox"/> 72197	MRA Neck/Carotids	<input type="checkbox"/> 70547	<input type="checkbox"/> 70549

OTHER: _____ CPT: _____