2880 TRICOM STREET NORTH CHARLESTON SC 29406
PHONE 843-266-4877 FAX 843-797-3633

SCHEDULING REQUEST

Date_____

IME ☐ WC Related ☐ MVA ☐ Second Opinion ☐ Other _____

PATIENT INFORMATION:

Name_____ Chart No_____

Home address: _____

Telephone: _____ DOB_____ SSN_____

Email: _____

REQUESTING PARTY INFORMATION:

Name_____

Position_____

Company_____

Telephone_____ Ext_____ Fax_____

CARRIER INFORMATION:

Company_____ Adjuster/POC_____

Address_____

Telephone _____ Ext_____ Fax_____

Accepted WC Case ☐ Yes ☐ No Claim No_____

EMPLOYER INFORMATION:

Company_____ POC_____

Address_____

Telephone_____ Fax _____

HISTORY OF INJURY:

DOI _____ WC Related ☐ MVA ☐ OTHER _____

Body Part_____ Previous MD_____

XR/MRI/CT Y N Facility _____ Date _____

XR/MRI/CT Y N Facility _____ Date _____

Physician Requested (Only for 2nd Opinion) _____

Exam Requested MMI ☐ IR ☐ TX RECOMMENDATIONS ☐ CAUSATION ☐ CURRENT CONDITION ☐

Patient's Attorney _____

Notes_____

REQUESTED BY _____ PHONE _____

FAX _____

LOWCOUNTRY ORTHOPAEDICS
-&- SPORTS MEDICINE
2880 TRICOM STREET NORTH CHARLESTON SC 29406
PHONE 843-266-4877 FAX 843-572-8364

EXAM REQUEST PROTOCOL

PATIENT NAME _____

The following items must be submitted to our office prior to the evaluation being scheduled:

1. A check in the amount of $1200.00 with no managed care reductions.
2. All pertinent medical records on the patient.
3. All pertinent radiological studies (actual film – not reports) on the patient.

The requester is responsible for forwarding all items to this office. We will not contact facilities or physicians' offices to request records/radiography studies. The requester is also responsible for ensuring that the check for the exam is in our office at least by the day of the exam. The exam will be rescheduled if we do not have the check. We will not submit any additional billing other than this invoice.

Once the records/radiography studies have been reviewed by our physician your office will be contacted and an appointment scheduled.

4. The fee for the evaluation includes a review of all medical records, radiological studies, a complete physical examination and a thorough written report. This will be held at our 2880 Tricom Street facility. The fee does not include any x-rays taken in our office during the evaluation. Further radiological studies may be needed to complete the exam.
   Your signature below will serve as your written authorization to take studies as needed with no managed care reduction. An invoice for these studies will be forwarded to your office immediately after the exam and payment is expected within seven (7) working days. The CPT code used for billing is 99456. Our federal tax ID number is 46-2535418. Please **do not include payment in a bulk check for payment on other accounts**. In addition, **the patient must present with a picture ID**. **In the event the patient fails to keep the scheduled appointment, there will be a $250.00 no show fee.** If one cannot be produced the appointment will have to be rescheduled. If you have any questions, you may contact me on my direct line at 843-266-4877. My direct fax number is 843-793-5410.

Tara Gerardi
Legal Support Specialist

_____ _____
Signature Date