



Phone: 512-444-8900 • Fax: 512-444-7244

NORTH / CEDAR PARK - HIGH FIELD MRI

715 Discovery Blvd. Ste # 102 • Cedar Park, TX 78613

CENTRAL - WEIGHT BEARING MRI

2745 Bee Caves Road, Ste #102 • Rollingwood, TX 78746

SOUTH - HIGH FIELD MRI

4316 James Casey St. Bldg F, Ste #110 • Austin, TX 78745

Please include a copy of the patient's insurance information.

Patient Name: _____	DOB: _____	Weight: _____	Height: _____
Phone/Home#: _____	Work/Other#: _____	Ins. Provider: _____	
Ins. Member#: _____	Ins. Group#: _____	Precert/Auth#: _____	

Referring Physician: _____	Contact Person: _____
Physician Phone#: _____	Physician Fax#: _____

☐ Report Only
 ☐ CD
 ☐ Films
 ☐ Images w/PT
 ☐ STAT

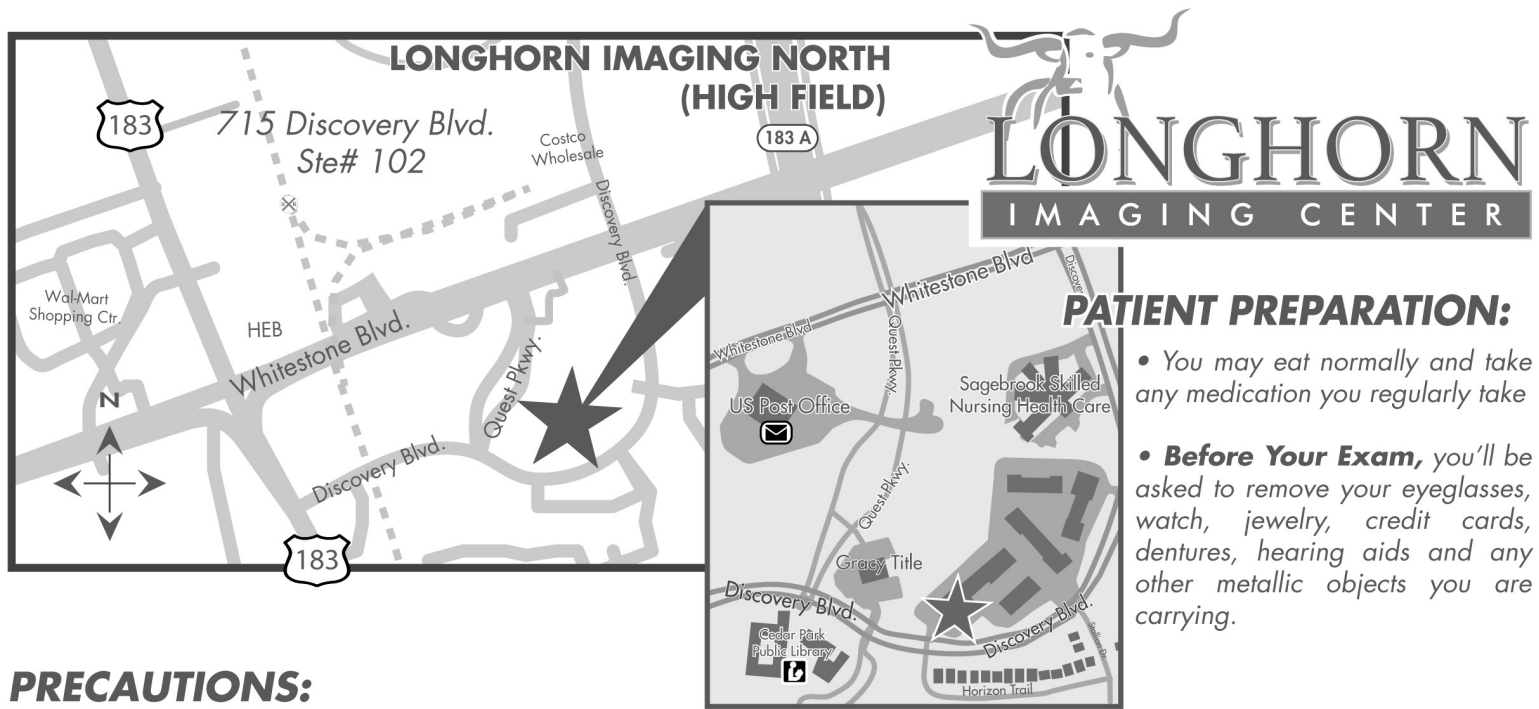
HIGH FIELD MRI				WEIGHT BEARING MRI		X-RAY	
HEAD AND NECK <small>MS PROTOCOL (CIRCLE)</small> Brain <input type="checkbox"/> <input type="checkbox"/> IAC's <input type="checkbox"/> <input type="checkbox"/> Pituitary - Sella <input type="checkbox"/> <input type="checkbox"/> Orbits <input type="checkbox"/> <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> <input type="checkbox"/> SPINE Cervical <input type="checkbox"/> <input type="checkbox"/> Thoracic <input type="checkbox"/> <input type="checkbox"/> Lumbar <input type="checkbox"/> <input type="checkbox"/> Pelvis <input type="checkbox"/> <input type="checkbox"/> Sacrum <input type="checkbox"/> <input type="checkbox"/> SI Joints <input type="checkbox"/> <input type="checkbox"/> MRA Intracranial (Circle of Willis) <input type="checkbox"/> <input type="checkbox"/> Carotid <input type="checkbox"/> <input type="checkbox"/> Renal <input type="checkbox"/> <input type="checkbox"/> Mesenteric <input type="checkbox"/> <input type="checkbox"/> Other: _____ MRV Brain <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>	CONTRAST WITH W/O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CONTRAST WITH W/O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CONTRAST WITH W/O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	L <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CONTRAST PER RADIOLOGIST PROTOCOL	EXTREMITIES Shoulder <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand: _____ <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Tib/Fib (lower leg) <input type="checkbox"/> Ankle <input type="checkbox"/> Foot: _____ <input type="checkbox"/> Femur <input type="checkbox"/> Other: _____ <input type="checkbox"/>	SPINE Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> ORTHO Shoulder (NON - WB) <input type="checkbox"/> <input type="checkbox"/> Elbow (NON - WB) <input type="checkbox"/> <input type="checkbox"/> Wrist (NON - WB) <input type="checkbox"/> <input type="checkbox"/> Hip <input type="checkbox"/> <input type="checkbox"/> Knee <input type="checkbox"/> <input type="checkbox"/> Ankle (NON - WB) <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> SPECIAL REQUEST FLEX / EXT: _____	L <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DIGITAL MOTION X RAY <input type="checkbox"/> VMA™ Cervical Exam <input type="checkbox"/> VMA™ Lumbar Exam <input type="checkbox"/> VMA™ Lumbar And Cervical Exam	<input type="checkbox"/> Complete <input type="checkbox"/> Limited <input type="checkbox"/> Pelvis <input type="checkbox"/> Ribs <input type="checkbox"/> Chest <input type="checkbox"/> 1v <input type="checkbox"/> 2v <input type="checkbox"/> Sinuses <input type="checkbox"/> KUB <input type="checkbox"/> Abdominal Series <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Extremity _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify) _____ _____	

ICD-10 Code/Diagnosis: _____

Special Instructions: _____

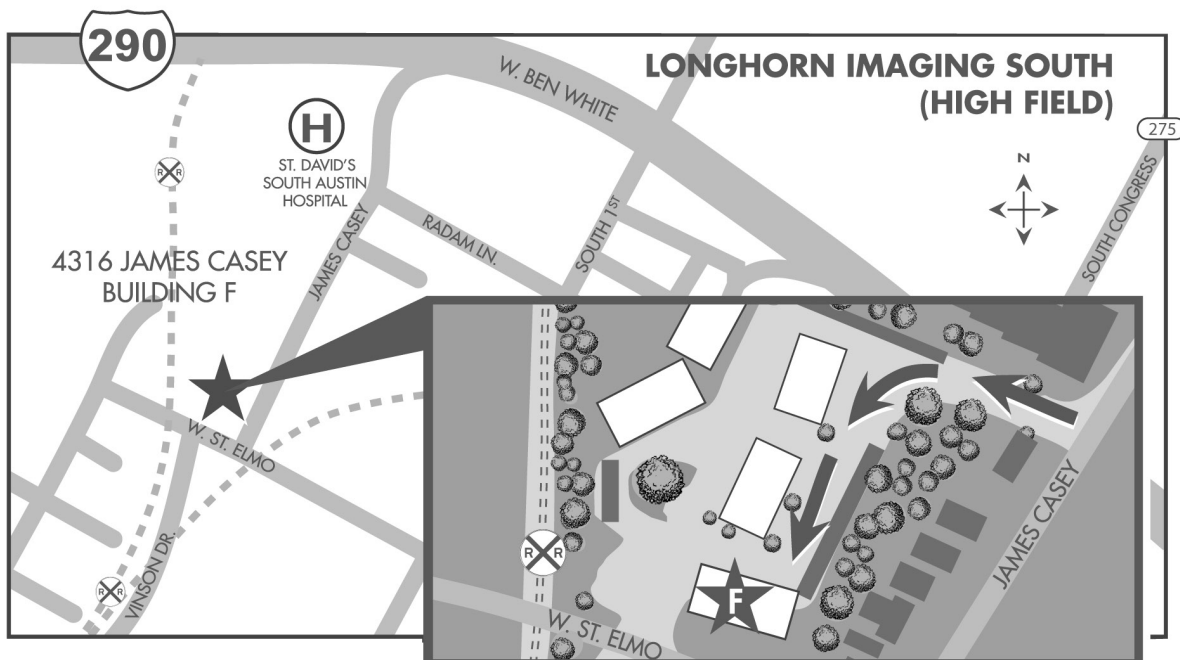
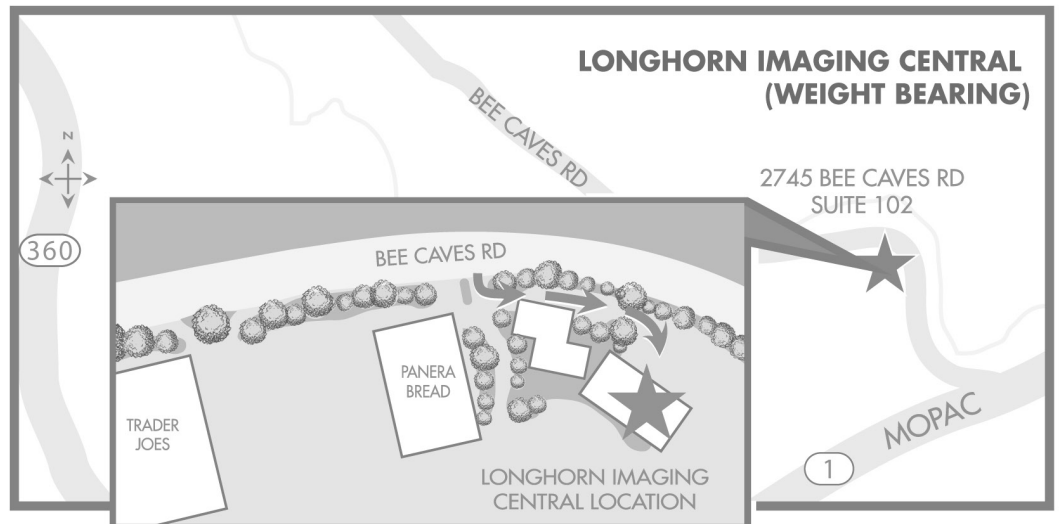
Physician Signature: _____

Our Service Will Have You Hooked!
 www.longhornimaging.com



PRECAUTIONS:

1. It is **VERY IMPORTANT** to tell the technician if you have, or think you have anything **metallic** in your body, which could be attracted by the magnet. These objects include metal plates, surgical clips, joint or bone pins, bullet fragments, shrapnel or BB shots.
2. Please bring previous X-ray, CAT scan's and MRI's concerning today's test.
3. Notify the technician if you are pregnant or think you might be pregnant.



PLEASE ARRIVE

30 minutes prior to your scheduled time. If for any reason you need to reschedule or cancel your appointment, you must call as soon as possible.



ACCEPTED INSURANCE

Absolute Solutions
ADIN Healthcare
Aetna
Aetna Medicare Plan
Aetna Work Comp Plan
AmeriPlan
Ancillary Care Services
BCBS
BCBS CHIP and STAR
BCBS HMO Blue
Beech Street
Care Improvement Plus
Care IQ
Cigna
Coast2Coast Diagnostics
Concentra
CoreChoice
Corvel
Cypress Care
Diagnostics Plus
DOL
Employer's Choice Network
Evercare Medicare (UHC)
FedMed
Galaxy Health Network
GENEX Services, Inc.

Great West
Humana
IMO, Inc.
Johnson & Associates, Inc.
Key Health Management
Lonestar Athletic Injury Network
MDM/DiaTri
Med-Eval (Injury Care Services)
Med Lien
Med Chex
Med Focus
Medicaid
Medicare
Med Options
Med Solutions
MedStar Funding
Midwest Medical HPO
MSAA
MTI (MedComp USA)
MultiPlan
NPN
Occu Comp
One Call Medical
Orchid Medical
PDM
Personal Injury/LOPS

PHCS (see MultiPlan)
Preferred Care
Preferred Physicians Funding, LLC (PPF)
Prime Health Services, Inc.
Provider Select, Inc.
Railroad Medicare
Secure Horizons (UHC)
Select MRI
Superior Health Plan
SWMPN
Tech Health
Texas Community Care
Three Rivers
TLC Advantage
Today's Options
TriCare
UMWA
Unicare
United American
United Healthcare
Universal Healthcare
USA MCO
US Imaging, Inc.
US Imaging, Inc., MA Plan.
Viant

Insurance List Updated June 2015

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