ARCIS Healthcare
LOWCOUNTRY ORTHOPAEDICS & SPORTS MEDICINE
2880 Tricom Street, North Charleston, SC 29406
Direct: 854.329.5418 | Office: 843.797.5050 | Legal: 843.266.4877 | Fax: 843.261.5752

SCHEDULING REQUEST

Exam Type: ☐ IME ☐ WC Related ☐ MVA ☐ Second Opinion

Other: **Date:**

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 Doctor:**

XR / MRI / CT: Y N **Facility:** **Date:**

XR / MRI / CT: Y N **Facility:** **Date:**

Physician Requested (2nd opinion only):

Exam Requested: ☐ MMI ☐ IR ☐ TX Recommendation ☐ Causation ☐ Current Condition

Patient's Attorney:

Notes:

Requested By: **Phone:**

Date: **Fax:**

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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 **$2,000.00** with no managed care reductions, submitted to 2880 Tricom Street, North Charleston, SC 29406, ATTN: Candace Middleton.
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 or 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 and 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 and 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 serves as 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.

Please note the following requirements:

- The patient must present with a picture ID. If one cannot be produced, the appointment will have to be rescheduled.
- In the event the patient fails to keep the scheduled appointment, there will be a **$250.00 no-show fee**.
- We will need the actual imaging as well as the imaging report. If your client cannot obtain the disk, please remind them to bring an actual disk of any imaging pertaining to the injured body part, or the information needed to obtain it directly from the facility. Failure to supply imaging could delay completion of the IME report.

If you have any questions, please contact me directly.

Candace Middleton
Legal Support Specialist
Direct: 854.329.5418 | Fax: 843.261.5752 | Email: candace.middleton@lowcountryortho.com

Signature: **Date:**