

BRAIN & NEUROSPINE CLINIC OF MISSOURI, L. L. C.

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Worker's Compensation Authorization

Visit authorized for **Patient Name:** _____

Please Check the Type of Visit

Independent Medical Examination – one time evaluation with rapid reporting that includes a complete neurological exam and a review of diagnostic testing, pertinent medical records, and pertinent diagnostic imaging studies. This report includes a diagnostic impression with reference to causation and whether maximal medical improvement (MMI) has been achieved. Further, it includes recommendations regarding any additional, necessary diagnostic studies and/or whether any additional treatment is likely to be beneficial. Expect the report to be faxed within 48 hours. *IME records over 1 inch in height will necessitate an additional charge for review.*

Evaluation and Treatment – consultation including review of new diagnostic imaging studies, coordination of care, and ongoing treatment.

One Time Visit – consultation that includes a complete neurological exam, review of diagnostic studies, formulation of diagnostic impression, and treatment recommendations. **(This is not applicable if the patient has been released at MMI or had a previous neurosurgical or orthopedic spine opinion.)**

All recommendations for further diagnostic studies and treatment will be submitted for approval before scheduling. Please send all pertinent prior medical records to us, along with this completed form. Should you have any specific questions to be addressed at the visit, please include them with this information. If your patient misses a scheduled appointment without prior notification, a fee of \$250 may apply.

If the completed authorization is not received at least 48 hours before the appointment, your patient may be rescheduled. Do not make any changes to this form. If you have billing questions, please call 573-339-1957.

Please provide the information below to facilitate the billing and payment process.

Please check one:

Mail Fax

Charges should be sent to:

Nurse Case Manager:

Claim #: _____

Claim #: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

E-Mail: _____

E-Mail: _____

Date of Injury: _____

Location of Injury: Back Neck Head Hands Other

I authorize payment in full for services provided to the above named patient at Brain & NeuroSpine Clinic of Missouri, L. L. C. Unless otherwise contracted: Currently we are contracted with: Beech Street, Comp Logic, Comp Results, Corvel, Healthlink, and Three Rivers. Subject to change)

Initialing and dating this form indicates your agreement and authorization.

Initial

Date

Name of Agent

Fax completed form to 573-339-9709 or E-mail to: tbriner@brainandneurospine.com