

RADIOLOGY QUESTIONNAIRE

Please fill out all required information that you would like added to MedLic's doctor directory.

NOTE: All doctors must be a licensed M.D., D.O.

Name of Clinic or Facility: _____

Name of Doctor: _____

License #: _____

M.D: _____ or D.O _____

Please specify if you are Board Certified: Yes: _____ No: _____

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

If you have more than one location, please add as many locations as you would like listed in the directory.

Location #2 Address:

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

Location #3 Address:

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

Appointments needed? Yes _____ No _____

Walk-ins accepted? Yes _____ No _____

Payment type accepted: Visa ____ MC ____ AE ____ Disc ____ Money Order _____

Cash ____ Personal Checks _____ Cashiers Check _____ Debit Card _____

(NOTE: All discounted rates per MedLic's Agreement will apply, unless the doctor's office chooses to accept the Athlete's personal insurance information. MedLic assumes no responsibility for any outstanding debt the Athlete may incur. Accepting insurance from an Athlete voids this contract and agreement for current appointment ONLY.)

➤ Do you need a prescription, referral or an order from a doctor?

➤ Yes: _____ or No: _____

➤ Please specify: _____

➤ Please specify if requesting images, the type available:

Film: _____ Disk: _____ Both: _____

➤ If the reading is not included and is sent to another facility, please provide the charge:

\$ _____

If the reading is done by an outside facility, please provide:

Facility name: _____

Name of doctor(s) doing the reading:

1. _____

2. _____

M.D: _____ or D.O: _____

Please specify if you are Board Certified: Yes: _____ or No: _____

License # _____

Contact name: _____

Facility number: _____

Facility email: _____

These are the different types of tests that a fighter will need to choose from to obtain a license to compete:

MRI of the brain (with contrast): test only \$_____ test with reading\$_____

MRI of the brain (without contrast): test only \$_____ test with reading \$_____

MRI scan is to be performed on a 1.5 or 3.0 Tesla MR machine with capabilities including fast spin echo and FLAIR imaging. Slice thickness is to be 5mm or less.

Image sequence should include axial T1,T2 and FLAIR images; coronal images should be performed as a T2 coronal through Hippocampus; Coronal Susceptibility Sequence (FFE); and a single sagittal FLAIR.

MRA of the brain: test only \$_____ test with reading \$_____

MRA scan is to include left and right internal carotids, vertebral and basilar arteries as well as the Circle of Willis.

Cat scan of the brain (with contrast): test only \$_____ test with reading \$_____

Cat scan of the brain (without contrast): test only \$_____ test with reading \$_____

EEG (Brain wave): test only \$_____ test with reading \$_____

Chest X-Ray: test only \$_____ test with reading \$_____

If your office provides a multitude of tests, please forward a list and send it to info@mymedlic.com along with MedLics discounted prices.

By signing this document, you are agreeing and allowing MedLic, LLC to list the contracted prices above in their directory.

Print Name: _____

Doctor Signature: _____

Date: _____



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