Pre-Service MRI Review Request Instructions

Thank you sincerely for choosing our services for the review of your medical images. It's a privilege to be entrusted with your healthcare. The pricing structure for the imaging review services has been set at $400.00. This fee encompasses a comprehensive review conducted by Dr. Keith Meister, along with a subsequent follow-up communication via phone consultation by a qualified member of Dr. Meister's team, delivering the results of the review. To be considered for an in-person evaluation a pre-service MRI review request form must be completed. Please complete the following steps in their entirety:

1. Complete and return via mail the below items to:

TMI Sports Medicine
Attn: MRI Review
3533 Matlock Road
Arlington, TX 76015

- The completed Pre-Service MRI Review Request Form
- MRI disc, MRI report, prior operative reports, and surgical pictures
- Any other pertinent medical records associated with the injury

2. Contact our office at 817-419-0303, selecting option 1. Please inform the associate that you wish to establish an account and proceed with payment for an imaging review service with Dr. Meister, which is priced at $400.00.

****** MRI reviews will be scheduled within 3-5 business days upon receipt of payment, submission of the required imaging, and completion of all necessary forms.******

****** All images received will be handled following HIPAA guidelines and securely destroyed after review unless a self-addressed and pre-stamped envelope is included with your imaging******

Thank you, we appreciate your trust in our services. If you have not been contacted within 7 business days, please reach out to us at records@tmisportsmed.com.

Pre-Service MRI Review Request Form

Demographic Information:

Patient's Legal Name: _____Patient's DOB:_____

Patient/Guardian's Phone Number (if pt is under 18): _____

Patient/Guardian's Email Address (if pt is under 18): _____

Do you have an advisor/agent? Yes No

Advisor/Agent Name:_____ Contact #:_____

Specific Sport Related Information Needed:

Primary sport played: _____

Current level of play (circle one): Youth High School Collegiate Professional Adult Recreational

If Collegiate, how many years of college eligibility is left? (Circle One): 1 2 3 4

Other sports played (circle all that apply): Football Tennis Track & Field Gymnastics Golf Basketball Other (please list): _____

Batting Specifics (Circle all that apply): Right Left Switch Hitter Pitcher Only

Throwing Specifics (Circle One): Right Left Both

Primary Position Played: (Circle One): Pitcher Catcher First Base Second Base Short Stop Third Base Outfield Utility

Career Aspirations:

_____

_____

Specific Injury Related Information:

Date of Onset / Injury: _____

How did the injury occur?

_____

_____

_____

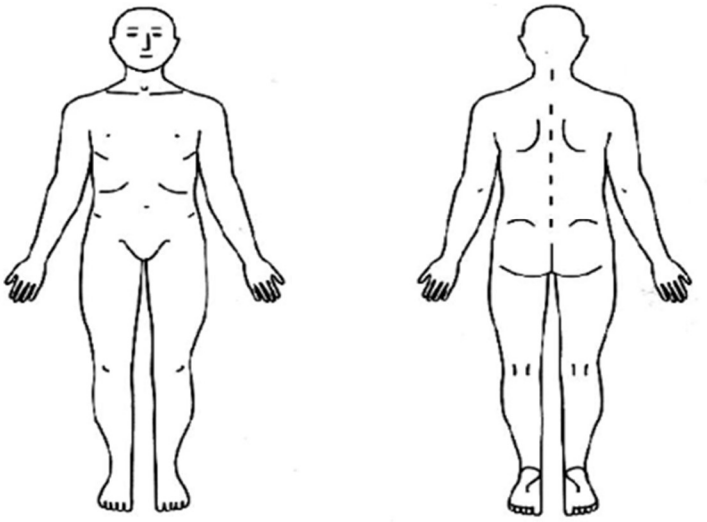
_____

Did you feel a pop? (Circle One) Yes No

Where is the pain located? Right Shoulder Left Shoulder Right Elbow Left Elbow

If you have pain throwing, where on the joint? Inside Outside Front Back

MARK AREAS OF DISCOMFORT



What phase of the throwing motion do you experience pain? (Circle all that apply)

Wind-up Early cocking Late cocking Acceleration Release Follow Through

Does the pain improve with warm up? Yes No Unsure

Do you have numbness or tingling in your ring and/or little finger when you throw? Yes No

What is the last date you threw a baseball? _____

What is the last date you pitched? _____

How many innings did you pitch over the last year? Please provide your best estimated number of innings: _____

TMI SPORTS MEDICINE

Current or Past Treatment for this specific injury such as medications, physical therapy, injections, etc. (please be specific):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Any previous injuries or surgeries on the involved extremity? Yes No

If yes, please explain in further detail and provide dates. Please send in a copy of the prior operative reports and surgical pictures with your current MRI scan(s).

_____
_____
_____
_____
_____
_____

For Pitchers Only:

Do you throw any of the below pitches? If so, please list your average velocity for each type of pitch.

Fastball: Yes No Average Velocity: _____

Curveball: Yes No Average Velocity: _____

Change Up: Yes No Average Velocity: _____

Slider: Yes No Average Velocity: _____

Sinker: Yes No Average Velocity: _____

Sweeper: Yes No Average Velocity: _____

Other: _____ Average Velocity: _____

Other: _____ Average Velocity: _____

We would like to stress the importance of understanding that while our review service offers valuable insights, it does not substitute a thorough, in-person physical examination. Our assessments are solely based on the provided imaging, which may not always offer a comprehensive depiction of the injury under consideration. If you are scheduled for further evaluation, additional imaging may be necessary to ensure an accurate assessment.

Your signature on this application is requisite, serving as both an acknowledgment and agreement to a hold harmless agreement. This indicates your understanding and agreement not to hold Keith Meister, MD, Keith Meister, MD PA or TMI Sports Medicine and Orthopedic Surgery liable for any potential issues that may arise.

It's crucial to emphasize that although our providers are not radiologists, our review service endeavors to provide beneficial insights. Nonetheless, it does not replace the necessity of an in-person evaluation. We sincerely appreciate your comprehension in this regard and eagerly anticipate the opportunity to provide further assistance.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFOMRATION AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE AND ACCEPT THE TERMS OF THIS AGREEMENT.

Signature:

_____

Printed Name:

_____

Relationship to Patient: _____ **Date:** _____

Patient's Name:

_____

Advance Notice of Non-Covered Services

Patient Name: _____

We anticipate that your insurance provider may not extend coverage for the evaluation of your medical records. It is important to note that insurance coverage applies only to specified healthcare services meeting the criteria outlined in your policy. Despite potential limitations in coverage, our provider remains committed to conscientiously examining your records, ensuring compatibility with your case, and delivering optimal care.

Service: Pre-Service Records Review

Because: It is deemed not medically necessary

The objective of this document is to confirm your acknowledgment and acceptance of the non-refundable fee of $400 for our provider's thorough review of your records and subsequent determination of the most suitable course of action. Please be aware that, despite this fee, our provider retains the discretion to decline your case.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Legal Representative

HIPAA Privacy Authorization

I understand that TMI Sports Medicine may still use and disclose protected health information as indicated in the Notice of Privacy Practices. If you would like to give some else access to your medical records, please list them below:

_____ No, do not share my medical records.

_____ Yes, I authorize TMI Sports Medicine to release information to the following individuals:

Full Name or Entity	Relationship	Phone	Authorized to Disclose:(CIRCLE ALL THAT APPLY)
1.			Medical Information / Billing Information
2.			Medical Information / Billing Information
3.			Medical Information / Billing Information
4.			Medical Information / Billing Information
5.			Medical Information / Billing Information

This authorization is being granted at the request of the individual. Unless otherwise revoked, this authorization expires 12 months after the date of signing this form.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

I understand that the information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Printed Name of Signer: _____

Relationship to Patient: _____

Signature: _____ Date: _____