



Request for Medical Services

_____ hereby authorizes The Feldman Institute to provide the designated medical services to the individual identified herein in accordance with the terms of our guaranty of payment to your facility.

Patient: _____ Date: _____

Address _____

Date of birth: _____ Date of accident: _____

SSN # _____ Phone # _____

Please check requested services:

- Patient evaluation/consultation _____
- Surgical evaluation _____
- Pre-op _____
- MRI – Without contrast _____
With contrast _____
With and without contrast _____
- CT - Without contrast _____
With contrast _____
With and without contrast _____
3D spine add to each above _____
- Sedation _____
- Digital X-ray _____
- Pump implant _____ Lumbar _____
Thoracic _____ Cervical _____
- Endoscopic Discectomy
1 level _____
2 level _____
- Discogram 1 level _____
- Myelogram _____
- ESI _____
- SI injections _____
CT guided _____
- Medical Branch Block _____
- Facet Injection _____
CT guided 1 level _____

Approved by _____

_____ Louisiana, this _____ day of _____