



Golden Rule
 Great West
 Gulf Coast Discount Medical
 Hartford Life
 Healthsease
 Humana
 Integrated Health Plan
 Interplan Health
 Manatee Choice Health Network
 Medicare / Railroad Medicare
 MedLink Healthcare Network
 Preferred Medical HMO
 Principal Life
 Preferred Care Partners
 Progressive Medical
 Secure Horizons
 Self Insured Plans (Not Self Insured Benefits)
 Senior Care
 Staywell
 TNR (Not Network Resources)
 Tricare/Champ VA
 Unicare
 United HealthCare
 Web TPA (not SMH Gulfcoast provider)
 Wellcare

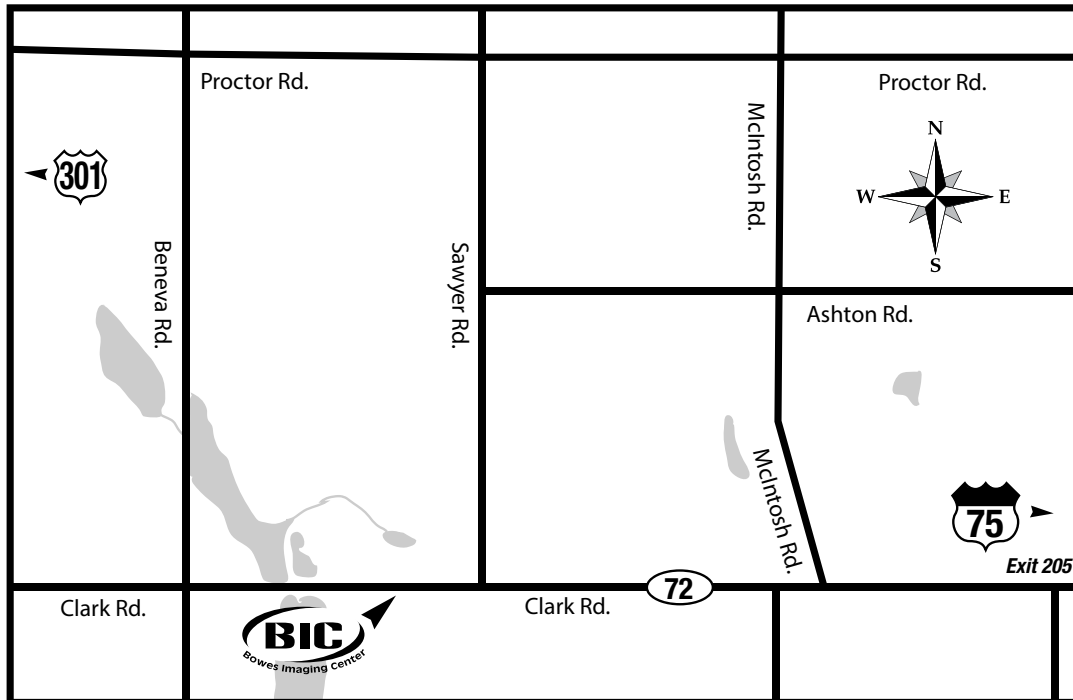
Some of Our Accepted Insurance Plans:
 If not listed, please call to verify

Advantage Care/ Metcare of Florida
 Aetna
 Ameriben
 Ancillary Care Services
 Assurant
 Avmed
 Beechstreet
 Blue Cross Blue Shield

CareMark
 CIGNA
 Conserve Care
 Core Source/Multiplan
 Coventry Heath/First Health
 Definity Health
 Empire (both BCBS and United Health Care)
 Evercare
 Evolutions (NOT SMH Gulf Coast Provider)
 Freedom Health Care/Optimum
 GEHA
 Genex/Independent Review Service
 GHI

We accept ALL Auto & Personal Injury insurance plans

We accept ALL worker's comp plans as long as we are in their auth/review network



From the North on US Hwy 301/Tamiami Trail:

- Head South on US Hwy 301/Tamiami Trail
- Turn left onto Stickney Pt. Rd.
- This turns into Clark Rd.
- Destination on the right
- 3900 Clark Rd.

From the South on US Hwy 301/Tamiami Trail:

- Head North on US Hwy 301/Tamiami Trail
- Turn right onto Stickney Pt. Rd.
- This turns into Clark Rd.
- Destination on the right
- 3900 Clark Rd.

From I-75:

- Take exit 205 Clark Road
- Head West
- Make a left on Sawyer
- Make a right into parking lot
- Destination on the left
- 3900 Clark Rd.

3900 Clark Road, Bldg. P
Sarasota, FL 34233



Phone (941) 924-8600
Fax (941) 924-2300
www.bowesimagingcenter.com

Patient's Name: _____ Physician's Name: _____

D.O.B.: _____ Physician's Signature: _____

Indication: _____ CC: _____

Diagnosis: _____ **Appointment On:** _____

SAME DAY APPOINTMENTS

AVAILABLE EVENINGS & WEEKENDS

MRI - NEURO/BODY			
	Without	With/Without	Contrast at Radiologist Discretion
VEN BOLD	<input type="checkbox"/>		
DTI (Diffusion Tensor Imaging)	<input type="checkbox"/>		
SWI	<input type="checkbox"/>		
BRAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IAC'S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PITUITARY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ORBITS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CERVICAL SPINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THORACIC SPINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LUMBAR SPINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NECK (SOFT TISSUE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PELVIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRI - MUSCULOSKELETAL					
			Without	With/Without	Contrast at RAD Discretion
SHOULDER	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ELBOW	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WRIST	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAND	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIP	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEE	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANKLE	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOOT	R	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MRA - ANGIOGRAPHY		
	Without	With/Without
CIRCLE OF WILLIS	<input type="checkbox"/>	
CAROTID ARTERIES	<input type="checkbox"/>	<input type="checkbox"/>
AORTA		
THORACIC		<input type="checkbox"/>
ABDOMINAL		<input type="checkbox"/>
RENAL ARTERIES		<input type="checkbox"/>
LOWER EXTREMITY-RUNOFF	R L	<input type="checkbox"/>
UPPER EXTREMITIES	R L	<input type="checkbox"/>

X-RAY			
CHEST PA & LAT	<input type="checkbox"/>	SHOULDER	<input type="checkbox"/> R L
ABDOMEN, KUB	<input type="checkbox"/>	ELBOW	<input type="checkbox"/> R L
ABDOMINAL SERIES	<input type="checkbox"/>	WRIST	<input type="checkbox"/> R L
PELVIS	<input type="checkbox"/>	HAND	<input type="checkbox"/> R L
C-SPINE	<input type="checkbox"/>	HIP	<input type="checkbox"/> R L
T-SPINE	<input type="checkbox"/>	KNEE	<input type="checkbox"/> R L
L-SPINE	<input type="checkbox"/>	ANKLE	<input type="checkbox"/> R L
		FOOT	<input type="checkbox"/> R L
OTHER:	_____		

CT			
<input type="checkbox"/> Without	<input type="checkbox"/> With/Without	<input type="checkbox"/> Contrast at Radiologist Discretion	
HEAD <input type="checkbox"/> Oral Contrast			
<input type="checkbox"/> HEAD	<input type="checkbox"/> SINUS	<input type="checkbox"/> TMJ	
<input type="checkbox"/> MANDIBLE	<input type="checkbox"/> ORBITS	<input type="checkbox"/> NECK (SOFT TISSUE)	
<input type="checkbox"/> TEMPORAL BONE	<input type="checkbox"/> OTHER _____		
SPINE			
<input type="checkbox"/> CERVICAL	<input type="checkbox"/> THORACIC	<input type="checkbox"/> SACRUM/COCCYX	
<input type="checkbox"/> LUMBAR	<input type="checkbox"/> OTHER _____		
MUSCULOSKELETAL			
<input type="checkbox"/> ANKLE: R L	<input type="checkbox"/> KNEE: R L	<input type="checkbox"/> HIP: R L	
<input type="checkbox"/> ELBOW: R L	<input type="checkbox"/> SHOULDER: R L	<input type="checkbox"/> OTHER _____	
BODY			
<input type="checkbox"/> CHEST	<input type="checkbox"/> RENAL COLIC	<input type="checkbox"/> UROGRAM	
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PELVIS	<input type="checkbox"/> OTHER _____	
CTA			
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> PULMONARY ARTERIES	<input type="checkbox"/> THORAX	
<input type="checkbox"/> CAROTID	<input type="checkbox"/> OTHER _____		

ULTRASOUND		
<input type="checkbox"/> CAROTIDS	<input type="checkbox"/> EXTREMITY	<input type="checkbox"/> PELVIC
<input type="checkbox"/> RENAL DOPPLER	<input type="checkbox"/> ABDOMINAL	<input type="checkbox"/> BREAST
<input type="checkbox"/> RENAL ULTRASOUND	<input type="checkbox"/> AAA	
<input type="checkbox"/> VENOUS: LEG: R L BILAT	ARM: R L BILAT	
<input type="checkbox"/> ARTERIAL: LEG: R L BILAT	ARM: R L BILAT	
OTHER:	_____	

STAT FAX to: _____

STAT CALL to: _____

Report Only Films with Patient CD with Patient

Films & Report to Office by: _____