

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

PATIENT _____ CLINIC _____ FILM DATE _____

AGE _____ SEX M F SOCIAL SECURITY# _____ / _____ / _____ DATE OF BIRTH _____

PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury. I hereby authorize the use of electronic transmission of records.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE : _____

DATE : _____

WITNESS : _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE