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

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CASH (no insurance) _____ MEDICARE ONLY _____ MEDICAID ONLY _____

STANDARD NEED **NON-PARTICIPATING** PROVIDER INSURANCE NAME & BILLING ADDRESS

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).

INSURANCE NAME & BILLING ADDRESS (PRIMARY)			INSURANCE NAME & BILLING ADDRESS (SECONDARY)		
CARRIER	TELEPHONE		CARRIER	TELEPHONE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____			RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____		
INSURED NAME	INSURED DATE OF BIRTH		INSURED NAME	INSURED DATE OF BIRTH	
INSURED SOCIAL SECURITY #	INSURED ID #		INSURED SOCIAL SECURITY #	INSURED ID #	
INSURED GROUP #	BCBS 3 LTR PREFIX		INSURED GROUP #	BCBS 3 LTR PREFIX	
INSURED EMPLOYER	TELEPHONE		INSURED EMPLOYER	TELEPHONE	
IF W/C: EMPLOYER ADDRESS	CITY	ST / ZIP	IF W/C: EMPLOYER ADDRESS	CITY	ST / ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATED TO EMPLOYMENT? YES ☐ NO ☐ AUTO ACCIDENT? YES ☐ NO ☐
OTHER? YES ☐ NO ☐

CLAIM # _____ DATE OF INJURY _____

W/C CARRIER or AUTO INSURANCE — NAME & BILLING ADDRESS LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)		ATTORNEY NAME & BILLING ADDRESS	
CARRIER	TELEPHONE	ATTORNEY NAME	TELEPHONE
INSURANCE ADDRESS		ATTORNEY ADDRESS	
CITY	STATE / ZIP	CITY	STATE / ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____		*PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)	
INSURED NAME	INSURED SOC. SECURITY #		
IF PI: ADJUSTERS NAME	ADJ: TELEPHONE	IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES	

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE