AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140 *(800) 442-1202*

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.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (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