Referring Doctor_____

Doctor's NPI Number_____

AUTO BILLING INFORMATION **Please complete the following information or attach a copy of your office records which contain <u>all</u> the necessary information.**

Patientõs Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Date of Birth _____ Sex ____

Insurance Company _____Policy#_____

Policyholderõs name (if different from patient) _____

Date of Accident _____ Claim #_____

Adjusterõs Name _____ Phone _____

Claims Address _____

_____

PATIENT AUTHORIZATION AND ASSIGNMENT

I consent that my x-rays will be interpreted by Radiology & Imaging Consultants, PA and that a formal written report will be issued to my chiropractorõs office to become part of my permanent treatment record. I understand that all charges from this consultation are ultimately my responsibility and separate from any charges at my chiropractorõs office.

I authorize the release of any medical information necessary to process this claim. I also authorize the direct payment of medical benefits to Radiology & Imaging Consultants, PA for services described above.

Patient's Signature_____
(Parent or guardian if minor child)

Date_____

A photocopy of this form shall be considered as valid as the original