LOGAN UNIVERSITY
CHIROPRACTIC HEALTH CENTERS

Please Print Patient Name

DEPARTMENT OF RADIOLOGY
INFORMED PATIENT CONSENT FOR IMAGING INTERPRETATION AND BILLING AUTHORIZATION

PATIENT INFORMATION

Patient Name _____ **Date of Birth**_____
Patient Address_____
_____ **Gender** □ **Female**
Patient Telephone_____**Cell**_____ □ **Male**

Guarantor_____
Guarantor Address _____
_____
Guarantor Telephone _____

Name of Insured _____ **Insured's Date of Birth**
Insurance Carrier_____ _____
Insurance ID_____ **Group #** _____
Insurance Address _____
Insurance Telephone_____ **SSN** _____

AUTHORIZATION AND ASSIGNMENT TO PAY PHYSICIAN:

I understand that my images and billing information has been sent to Logan College of Chiropractic Radiology Department for interpretation/consultation. I hereby authorize the doctor to furnish you the information and evidence in the doctor's possession regarding my history and physical condition. I hereby authorize the release of any medical information necessary to process this claim and you are instructed to pay directly to the doctor, at the doctor's office, for all diagnostic and professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid amounts for diagnostic and consultant (x-ray interpretation) services. In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment. I fully understand that I am directly and fully responsible to said doctor for all diagnostic and professional bills submitted by him for services rendered to me and that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. Medicare regulations do not require x-rays and will not pay for these services.

PATIENT NAME, DATE & SIGNATURE

_____ _____
Print Name **Today's Date**

_____
Patient or Authorized Representative's Signature