

LOGAN UNIVERSITY

CHIROPRACTIC HEALTH CENTERS

DEPARTMENT OF RADIOLOGY IMAGING INTERPRETATION REQUEST

PATIENT INFORMATION

Patient's First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____

Patient's Address _____

Gender Female

Male

City _____

State _____

Zip _____

Patient's Telephone # _____

Patient's Cell # _____

Insurance Company _____

File Insurance Yes

No

If Patient's insurance is in network, Logan will file the charges and bill the referring doctor for balance. If you would like the insurance filed, please fill out patient insurance form and include a copy of patient's card.

PATIENT'S HISTORY

Patient's Chief Complaint _____

Surgeries _____

Trauma _____

History of Cancer? Yes No

Type _____

Diagnosis _____

IMAGES SUBMITTED FOR CONSULTATION

List Study _____

REFERRING DOCTOR INFORMATION

Referring Doctor _____

e-mail _____

Referring Doctor's Address _____

Suite _____

License Number _____

City, State, Zip _____

NPI _____

Telephone _____

Fax _____

Doctor's _____

Signature _____

Date _____

Services rendered for all Logan Radiology interpretations/consultations will be the referring doctor's financial responsibility, with payment expected within 30 days of receipt of an invoice. If Patient's insurance is in network, Logan will file the charges and bill the referring doctor for balance. If you would like the patient's insurance filed, please fill out patient insurance form and include a copy of patient's insurance card. Thank you in advance for your cooperation and continued business.

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