LOGAN UNIVERSITY
CHIROPRACTIC HEALTH CENTERS

DEPARTMENT OF RADIOLOGY

IMAGING INTERPRETATION INSURANCE AND BILLING AUTHORIZATION

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 INFORMATION

_____ _____

Insured's First Name ***Middle Initial*** ***Last Name*** ***Insured's Date of Birth***

_____

Insured's Address

Gender ☐ ***Female***
☐ ***Male***

_____

City ***State*** ***Zip***

_____ _____

Relationship to Patient ***Insured's Telephone #***

_____ _____

Insurance Carrier ***INSURANCE ID #***

_____ _____

Insurance Address ***INSURANCE GROUP #***

PATIENT NAME, DATE AND SIGNATURE

INSURANCE AUTHORIZATION:

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.

_____

Print Patient Name

_____ _____

Patient or Authorized Representative's Signature ***Date***

REVISED JULY 1, 2016