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

_____ _____
City *State* *Zip* ***Gender** (female, male)*

_____ _____
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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