

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140

(800) 442-1202

COMPLETE CHIROPRACTIC

PATIENT _____ CLINIC _____ FILM DATE _____

AGE _____ SEX M F SOCIAL SECURITY # _____ / _____ / _____ DATE OF BIRTH _____

PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____

DATE: _____

WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140

(800) 442-12...

CASH (no insurance) _____ MEDICARE ONLY _____ MEDICAID ONLY _____

STANDARD

NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS

INSURANCE NAME & BILLING ADDRESS				INSURANCE NAME & BILLING ADDRESS					
CARRIER		TELEPHONE		CARRIER		TELEPHONE			
ADDRESS				ADDRESS					
CITY		STATE	ZIP	CITY		STATE	ZIP		
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____					
INSURED NAME		INSURED DATE OF BIRTH		INSURED NAME		INSURED DATE OF BIRTH			
INSURED SOCIAL SECURITY #		INSURED ID #		INSURED SOCIAL SECURITY #		INSURED ID #			
INSURED GROUP #		BCBS 3 LTR PREFIX		INSURED GROUP #		BCBS 3 LTR PREFIX			
INSURED EMPLOYER		TELEPHONE		INSURED EMPLOYER		TELEPHONE			
EMPLOYER ADDRESS		CITY	ST	ZIP	EMPLOYER ADDRESS		CITY	ST	ZIP

AUTO ACCIDENT/PI/WORKERS COMPENSATION

RELATED TO EMPLOYMENT? YES NO AUTO ACCIDENT? YES NO
OTHER? YES NO

CLAIM # _____ DATE OF INJURY _____

W/C CARRIER or AUTO INSURANCE	NAME & BILLING ADDRESS <small>LIST BOTH LIABILITY AND MED PAY CARRIERS / USE ADDITIONAL PAPER IF NECESSARY</small>	ATTORNEY NAME & BILLING ADDRESS			
CARRIER	TELEPHONE	ATTORNEY NAME	TELEPHONE		
INSURANCE ADDRESS		ATTORNEY ADDRESS			
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____		* PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY			
INSURED NAME	INSURED SOCIAL SECURITY #				
PI: ADJUSTER'S NAME	ADJ. TELEPHONE	ALLOWED DIAGNOSIS ICD-9 CODES			

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE