ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

PATIENT _____ CLINIC Stern Chiropractic 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 Advantage Radiology Service (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:_____

FOR OFFICE USE ONLY

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

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CASH (no insurance)_____ MEDICARE ONLY _____ MEDICAID ONLY_____

STANDARD

NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS
*PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).

INSURANCE NAME & BILLING ADDRESS PRIMARY			INSURANCE NAME & BILLING ADDRESS SECONDARY		
CARRIER	TELEPHONE		CARRIER	TELEPHONE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER_____			RELATIONSHIP TO INSURED SELF SPOUSE CHILD 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	

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

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

DATE OF INJURY_____

W/C CARRIER OR AUTO CARRIERS			ATTORNEY NAME & BILLING ADDRESS		
CARRIER	TELEPHONE		ATTORNEY NAME	TELEPHONE	
INSURANCE ADDRESS			ATTORNEY ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____			*PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY		
CLAIM NUMBER	INSURED NAME		IF W/C: EMPLOYER ADDRESS	CITY / ST	ZIP
IF PI: ADJUSTERS NAME	ADJ: TELEPHONE		IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES		

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE