

**DIAGNOSTIC IMAGING CONSULTANTS, INC.
11123 MONTGOMERY ROAD
Suite #201
CINCINNATI, OHIO 45249
(513) 489-0055
FAX: (513) 489-4587**

**ASSIGNMENT OF BENEFITS
FOR RADIOGRAPHIC INTERPRETATION**

I understand that to insure the highest quality of interpretation of my x-rays, the services of a certified chiropractic radiologist are being utilized. This fee is separate from that of the chiropractic clinic. I also understand that the fees for this service will be submitted to my insurance carrier, Worker's Compensation, or attorney in the case of personal injury.

I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible, or the balance due stated by my insurance company as my responsibility.

In the event that I receive payment for the services I agree to promptly remit payment to Diagnostic Imaging Consultants.

I acknowledge and give my consent to have my x-rays interpreted by Dr. Bryan Hosler, DACBR . I understand that any balance due is my responsibility.

SIGNATURE: _____ **DATE:** _____

Healthcare information is sensitive information. It is being sent to us after the appropriate authorization of the patient. We the recipient are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure could subject penalties described in federal law.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

**DIAGNOSTIC IMAGING CONSULTANTS, INC.
Suite # 201
11123 MONTGOMERY ROAD
CINCINNATI, OHIO 45249**

SIGNATURE: _____ **DATE:** _____

WITNESS: _____