

DIAGNOSTIC IMAGING CONSULTANTS, INC.
10751 MONTGOMERY ROAD
CINCINNATI, OHIO 45242
513 489 0055
FAX 513 489 4587

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: _____

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

DIAGNOSTIC IMAGING CONSULTANTS, INC.
10751 MONTGOMERY ROAD
CINCINNATI, OHIO 45242

SIGNATURE: _____ DATE: _____

WITNESS: _____

PLEASE MAKE SURE ALL INFORMATION IS COMPLETED WITH EACH SET OF FILMS

CLINIC NAME: WARDS CORNER CHIROPRACTIC & SPORTS REHAB

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____

BIRTH DATE: _____ MARITAL STATUS: M S D W

SOCIAL SECURITY #: _____ SEX: F M

INSURANCE COMPANY (ONLY) ATTACH COPY OF CARD

INSURED'S NAME: _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____

POLICY #: _____ GROUP #: _____

DATE OF INJURY: _____ DATE OF ILLNESS: _____

DIAGNOSIS CODE NUMBERS: _____

ATTORNEY (ONLY)

ATTORNEY'S NAME: _____ DATE OF INJURY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____