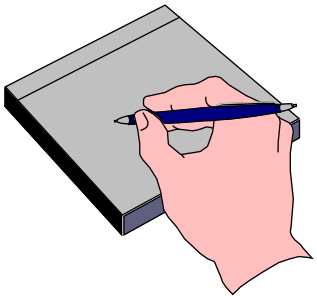
Radiologic Consulting

Referral Information

John Miller, DC, DACBR
9015 Holman Rd NW, Suite 3
Seattle, WA 98117
phone (206) 784-8119
fax (206) 784-4020
Email: drjohn@drjmiller.com

Information to be included for X-ray Interpretation



(Please make extra copies of pages 4-6 before using)

1. Fill Out the X-ray Request Form

2. Complete the X-ray Billing Form

or

Include your insurance intake form

3. Have the patient sign our Billing Form

4. For 3rd party PI, Have patient sign our Assignment to Pay Doctor Form

Our Billing Procedures

We Bill

•Major Insurance Companies

-if Chiropractic benefits are included

•Labor and Industries

-no pre-authorization required

•Automobile Insurance

- on PIP cases
-liens filed on 3rd party cases (attorney required)
    - Assignment form must be signed by patient
    - Patient billed directly if 3rd party case under $225 or if no attorney

•Attorneys

-for film reading service of $225 or more
- patient must sign our "Assignment to Pay Doctor" form

•Cash Patients

-billed directly to patient
-patient billed on 3rd party PI under $225 and/or if no attorney is listed
-patient billed on Medicare cases

-Patient's address, social security number, signature and date needed in all cases.

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Request for X-ray Consultation

Requesting Dr.

Dr_____Phone ( )_____

Address_____

City_____State_____Zip_____

NPI # _____

Patient:

Name_____Age_____Sex_____

Occupation_____

Area of x-ray study_____

Chief Complaint:

_____

_____

Clinical Findings:

_____

_____

History:

Recent Trauma (Date)_____

Surgery_____

Other History_____

Any Questions on these x-rays_____

_____

_____

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Billing Information for X-ray Consultation

Patient's Name_____

Address_____

City, State, Zip_____

Phone #_____

Date of Birth_____

Social Security #_____ ☐ ☐

Insurance Company Name_____

Insurance Address_____ PIP 3rd Party

City, State, Zip_____

Insurance Adjustor Name and Phone #_____

Insured's Name_____

Insured's ID #_____

Insured's Group or Claim #_____

Date of Injury_____

Diagnosis Billed Under_____

Labor and Industries

Claim #_____

Employer _____

Attorney Name_____

Attorney Address_____

Attorney Phone #_____

I request Radiologic Consultation by John Miller, DC, DACBR and assign all benefits payable for such services to Dr. Miller. I authorize assignee to release all information necessary to secure payment in full. I understand that I am financially responsible for all charges whether or not paid by said insurance company, and that these services are not covered by Medicare, Aetna, or United Health Care.

Patient Signature_____Date_____

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Assignment to Pay Doctor Directly

To:

Re:

I hereby authorize and direct you, my attorney, to pay directly to John Miller, DC, DACBR such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further consent to a lien being filed on my case by said health care provider against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have received medical services.

I fully understand that I am directly and fully responsible to said health care provider for all medical bills submitted by him for services rendered me and that this agreement is made solely for said health care provider's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Please acknowledge this letter by signing below and returning to the health care provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the health care provider's interest, the provider will not await payment, but will require me to make payments on a current basis.

Dated:_____ _____

Signature of Patient

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said health care provider named above.

Dated:_____ _____

Signature of Attorney

Please date, sign, and return a copy to this office.

Thank you.