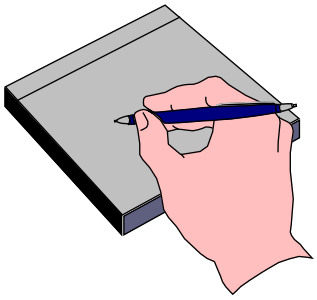
Radiologic Consulting

Referral Information

John S. Miller, DC, DACBR, PS
9015 Holman Rd NW, Suite 3
Seattle, WA 98117
phone (206) 784-8119
fax (206) 784-4020
Email: jsmiller2@mindspring.com

Information to be included for X-ray Interpretation



(Please make extra copies of pages 4 and 5 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. No 3rd party cases, Medicare or Major Medical for 2nd opinions

Our Billing Procedures

We Bill

•Labor and Industries

-no pre-authorization required
-must include the accepted diagnoses

•Automobile Insurance

- on PIP cases only

•Cash Patients or Not Covered by Insurance

-patient prepays through my website.
-call for pricing based on views being submitted.

-Patient's address, social security or driver's license 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 or Driver's license#_____

Auto Insurance Company Name_____ ☐

Insurance Address_____ PIP

City, State, Zip_____

Insurance Adjustor Name and Phone #_____

Insured's Name_____

Claim #_____

Date of Injury_____

Diagnosis Billed Under_____

Labor and Industries

Claim #_____

Employer _____

Accepted L&I case diagnoses_____

I request Radiologic Consultation by John S. 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, Medicaid, Aetna, Cigna, Premera Blue Cross, Regence Blue Shield, or United Health Care.

Patient Signature_____Date_____