

LOGAN UNIVERSITY

HEALTH CENTERS

DEPARTMENT OF RADIOLOGY

IMAGING INTERPRETATION INSURANCE AND BILLING AUTHORIZATION

PATIENT INFORMATION

Patient's First Name *Middle Initial* *Last Name*

Date of Birth

Patient's Address

Gender *Female*
 Male

City *State* *Zip*

Patient's Telephone #

Patient's Cell #

INSURANCE INFORMATION

Insured's First Name *Middle Initial* *Last Name*

Insured's Date of Birth

Insured's Address

Gender *Female*
 Male

City *State* *Zip*

Relationship to Patient

Insured's Telephone #

Insurance Carrier

INSURANCE ID #

Insurance Address

INSURANCE GROUP #

PATIENT NAME, DATE AND SIGNATURE

INSURANCE AUTHORIZATION:

I understand that my images and billing information has been sent to Logan College of Chiropractic Radiology Department for interpretation/consultation. I hereby authorize the doctor to furnish you the information and evidence in the doctor's possession regarding my history and physical condition. I hereby authorize the release of any medical information necessary to process this claim.

Print Patient Name

Patient or Authorized Representative's Signature

Date