DIAGNOSTIC IMAGING CONSULTANTS, INC.

3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587
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:_____

Heathcare information is sensitive information. It is being sent to us after 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.
3296 W STATE ROUTE 22-3
LOVELAND, OHIO 45140-4587

SIGNATURE: _____ DATE:_____

WITNESS:_____