AUTHORIZATION OF SERVICES FOR RADIOLOGIST / BILLING FORM *Brooke L. Gajeski, DC, DACBR*

SAFEGUARD Radiology Interpretation Services
9462 Brownsboro Rd., #268, Louisville, KY 40241 Phone: (502) 961-0011 Fax: (502) 427-7797

Referring Doctor/Office Name (Please Print): _____

Patient Demographic Information: (Please Print)

Patient Name: _____ DOB: _____ Gender: M or F (circle one)

Address: _____City/State/Zip _____

Phone: _____ SS#: (PI Case only) _____

Patient Symptoms /Comments / History: (May attach a separate page if needed)

Chief Complaint: _____

Trauma/Cancer/Surgeries: _____

_____

CASH- Referring Doctor Payment
Payment Selection (Check One)

Check/ACH Self Pay _____

Credit Card Self Pay _____

Credit Card Auto Pay_____ (Auth Required)*

Personal Injury –Billing Selection (Check One)

Primary Opinion* _____ Second Opinion _____

*If requesting Primary Opinion-please provide CPT codes billed w/-TC modifier

_____-TC _____-TC _____-TC _____-TC

Auto Insurance (Personal Injury)

Company: _____

Address: _____

City, State, Zip: _____

Claim/Policy #: _____Date of Injury_____

Adjustor: _____

Phone#: _____

Diagnosis Codes: _____ _____ _____ _____

Attorney Information (Personal Injury)

Law Firm: _____

Attorney Name: _____

Address: _____

City, State, Zip: _____

Claim/Policy #: _____

Date of Injury:_____

Phone #: _____

Authorization of Services / Release of Medical Information

I acknowledge and understand that my imaging studies are being sent to Safeguard Radiology Interpretation Services, LLC (SRIS) for interpretation and production of the written report by Brooke L. Gajeski, DC, DACBR. I understand that if my case is a personal injury case, i.e. PI case, that SRIS will bill my auto insurance carrier and/or assigned attorney for this service. I authorize the release of my medical records to the auto insurance carrier and or my attorney of record**. I also authorize that any payments from the insurance carrier and/or attorney for this/these written report(s) are to be made directly to SRIS.** If I instead receive the payment(s) for services performed by SRIS, I will forward the payment(s) to SRIS in a timely manner**. I understand that ultimately, I am responsible for any unpaid balance (depending on insurance coverage).** Photocopies of this assignment by signature below will be accepted as effective and valid as the original.

_____

Signature of Patient Date Signed

If patient is a minor, indicate relationship of adult signer to patient: _____