Chiropractic Patient Referral

2925 Ryan Drive SE • Salem, Oregon 97301 • Phone: 503.399.1262 • Fax: 503.371.0777

Please complete the back of this form, and bring it with you for your appointment.

Patient Name:_____ Date of Birth: _____

Ordering Physician: _____
PRINTED NAME SIGNATURE

Physician Phone #: _____

History and Tentative Diagnosis:

_____

_____

_____

Reporting Instructions:

0 Routine Report

0 STAT Phone Results
Direct Phone # _____
Have Patient: 0 Wait 0 Leave

0 STAT Fax
Fax # _____

Imaging Requested:

X-ray:

0 Cervical Spine
- 0 AP, APOM, Lat
- 0 AP, APOM, Lat, Flex, Ext
- 0 AP, APOM, Lat, Obl
- 0 Davis Series (All of the above)

0 Lumbar Spine
- 0 AP, Lat
- 0 AP, Lat, Lat L/S Spot
- 0 AP, Lat, Obl
- 0 + Flexion/Extension
- 0 + Lateral Bending

0 Thoracic Spine
- 0 AP, Lat, Swimmers
- 0 AP, Lat

0 Sacrum
- 0 AP, Lat

0 Coccyx
- 0 AP, Lat

0 Other (specify): _____

MRI:

0 Cervical Spine
0 Thoracic Spine
0 Lumbar Spine
0 Extremity
0 Other (specify): _____

Please call for an appointment

Bone Densitometry:

0 Bone Density Testing

(Take no calcium the day of exam)

Please call for an appointment

! NOTE: CT, ULTRASOUND AND MAMMOGRAPHY ARE ALSO AVAILABLE AT SRC

Patient Information

Patient's Name:_____ Sex: OM OF

Mailing Address:_____Apt.#_____

City:_____State:_____Zip:_____

Phone (Home):_____Age:_____Birth Date: _____

Phone (Work):_____S.S.# _____

Insurance Information will be needed at each visit.

On Job or Auto Claim? Y N Injury Date: _____

Before your appointment, please complete the patient information, and bring it with you for your appointment.

Visit us on-line at www.salemradiology.net

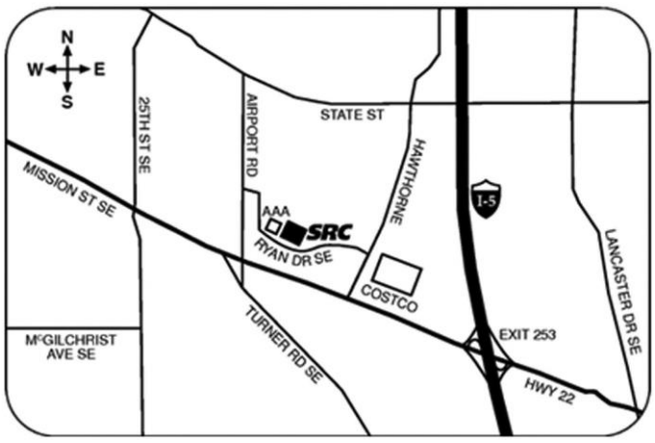
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURANCE Medical Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary and secondary insurance company as a courtesy to you after receiving a copy of your current insurance card. If you have a balance on your account, we will send you a monthly statement after your insurance has been billed. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance which may include the full amount of charges if the insurance company denies coverage. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from the insurance company.

FINANCE CHARGE AND PAST DUE ACCOUNTS A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of one point zero (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). If your account becomes past due, we will take all necessary steps to collect the account balance which may include referral to an independent collection agency.

SIGNED:_____DATE: _____



Our Location:

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