PALMER Chiropractic Clinics

4705 S. Clyde Morris Blvd
Port Orange, FL 32129
Business (386) 763-2615
Fax (386) 763-2692

Imaging Consultation Services

Patient's Name: _____ Age: _____ Sex: M / F

Referring Doctor: _____ NPI: _____

Chief Complaint, Area of Concern: _____

Previous Diagnosis, Surgery, Trauma, Cancer, _____ ☐ Include Previous Imaging Reports

Date of Examination: _____ Verbal Report ( )_____ FAX Report ( ) _____

☐ Payment Enclosed (Master Card, Visa, Discover, American Express or Check) **20% POS Discount**.

☐ INSURANCE billing-assumes DC billed TC ☐ Bill Doctor

Card Type: _____ Card #: _____ Expiration Date: _____ V-Code: _____

Submit Copy of Insurance Card / Documentation OR Complete the Following:

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Date of Birth: _____ / _____ / _____ SS #:_____

Patient's Employer: _____ Work Phone ( ) _____

Primary Insurance Company: _____ Adjustor: _____

Address: _____ City: _____ State: _____ Zip: _____Phone: ( )_____

Policy #: _____ Claim #: _____ Group/Plan: _____

First Insured's Name: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Relationship: ☐ Spouse ☐ Child ☐ Other _____

Insured's Employer:_____

Related to Employment: ☐ Accident? ☐ Date: _____ / _____ / _____ State:_____

Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____Phone: ( )_____

Patient Consent:
I understand that this office will have my radiographs interpreted by Matthew Richardson, D.C., DACBR, a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize Palmer Chiropractic Clinics assignment of benefits for services rendered directly from my insurance carrier or attorney. Accordingly I authorize Palmer Chiropractic Clinics to obtain information necessary to secure payment of benefits and authorize the use of this signature on associated benefit submissions. I also, authorize the release of any medical information necessary to process this claim. Any amounts owed but not collected will be my responsibility.

<u>This service is not covered by Medicare</u>:

Patients/Guardian Signature: _____ Date: _____

PALMER IMAGING CONSULTATION SERVICES

√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3v	$24.00		73030-26	Shoulder 2v	$24.00		73600-26	Ankle 2v	$24.00
	72050-26	Cervical 4v	$30.00		73080-26	Elbow 2-4v	$24.00		71010-26	Chest 1v	$24.00
	72052-26	Cervical 6v	$30.00		73100-26	Wrist 3v	$24.00		71020-26	Chest 2v	$24.00
	72070-26	Thoracic 2v	$24.00		73120-26	Hand 3v	$24.00		72010-26	Spine, entire	$70.00
	72100-26	Lumbar 2v	$24.00		73510-26	Hip Uni 2v	$24.00		72148-26	MRI – Over read	$70.00
	72110-26	Lumbar 4-5v	$30.00		73560-26	Knee 2v	$24.00				
	71101-26	Ribs 3v	$24.00		73630-26	Foot 3v	$24.00				

Diagnosis Codes: 1._____ 2. _____ 3._____ 4._____

mdr 6/14