



1000 Brady Street  
 Davenport, IA 52803  
 Business (563) 884-5805  
 Fax (563) 884-5581

**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 (-27)  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 Ian McLean, D.C., D.A.C.B.R., 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.

**This service is not covered by Medicare:**

**Patients/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PALMER IMAGING CONSULTATION SERVICES											
√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3v	\$20.00		73030-26	Shoulder 2v	\$20.00		73600-26	Ankle 2v	\$20.00
	72050-26	Cervical 4v	\$25.00		73080-26	Elbow 2-4v	\$20.00		71010-26	Chest 1v	\$20.00
	72052-26	Cervical 6v	\$25.00		73100-26	Wrist 3v	\$20.00		71020-26	Chest 2v	\$20.00
	72070-26	Thoracic 2v	\$20.00		73120-26	Hand 3v	\$20.00		72010-26	Spine, entire	\$60.00
	72100-26	Lumbar 2v	\$20.00		73510-26	Hip Uni 2v	\$20.00		72148-26	MRI – Over read	\$60.00
	72110-26	Lumbar 4-5v	\$25.00		73560-26	Knee 2v	\$20.00				
	71101-26	Ribs 3v	\$20.00		73630-26	Foot 3v	\$20.00				

Diagnosis Codes: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_