REFERRING PHYSICIAN: FOUNDATION SPORT & SPINE

TYPE OF CASE: _____ GRP. HEALTH _____ MEDICARE _____ WORK COMP _____ PI _____ PROVIDE DIGITIZED REPORT

_____ BILL PATIENT _____ BILL DOCTOR Date Of Accident: ______________________________
(Work Comp and PI)

PATIENT INFORMATION:

LAST NAME: ______________________________________ FIRST NAME: ______________________________________

ADDRESS: ____ CITY: _________________________ STATE: ______ ZIP: __________

TELEPHONE: ( ) ________________________ DOB:_____ /______ /______ SS# __________ -________ - _______

E-MAIL ADDRESS: ____

SEX: M O R F RELATION TO INSURED: SELF SPOUSE CHILD OTHER ______________________

EMPLOYER: ____ PHONE # : ________________________

ADDRESS: ____ CITY,ST,ZIP ___________________________________

~ ~

ATTORNEY INFORMATION:

NAME: ____ PHONE #:______________________________________

ADDRESS: ____ CITY, ST, ZIP ___________________________________

~ ~

INSURANCE INFORMATION:	PRIMARY	SECONDARY
INSURANCE NAME:	______________________________________	____
INS. ADDRESS:	____	____
INS. CITY / STATE / ZIP:	___________________________________	____
INS ID# / CLAIM NUMBER:	________________________________	____
GROUP: __________________	PH# _________________________	______________________________PH# ______________
INSURED IF DIFF. FROM PT:	_______________________________	____

I,________________________________ understand there will be a **separate bill** for SRC's radiology interpretation and written report. I also authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to SRC **and accept responsibility for any remaining balance**.

I consent to Specialized Radiology Consultants ("SRC") use and disclosure of my Protected Health Information for the purpose of providing radiology readings on me, for purposes relating to the payment of services rendered to me, and for SRC's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management, and other general operation activities, I understand that the SRC's diagnosis of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, **"Protected Health Information"** means any information, including my demographic information, created or received by SRC, that relates to my past, present, or future physical or mental health or condition: the provision of health care to me; or the past, present, or future payment for the provision of health care services to me: and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of SRC, but SRC is not required to agree to these restrictions. However, if SRC agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the SRC's Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I understand that if I desire a copy, I may call the above number and one will be copied and mailed to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or SRC has acted in reliance on this consent.

____ DATE: ______________________________
Signature of Patient or Personal Representative

SPECIALIZED RADIOLOGY CONSULTANTS
WHEATON, IL (630) 462-9772