Professional Imaging Consultants, Inc. Edward J. Dailey, DC, DACBR
PO Box 36952 Canton, OH 44735 T: 330-498-9445 Fax: 330-498-9447

Clinic / Doctor: ____

BILLING INFORMATION FORM

TYPE OF CASE

- ☐ Insurance
- ☐ Medicaid
- ☐ Work Comp
- ☐ Medicare
- ☐ Personal Injury
- ☐ Time of Service
- ☐ Cash
- ☐ 2nd Opinion
- ☐ Bill Doctor
- ☐ Hardship

PATIENT INFORMATION (Complete For All Patients)

Name: ____

Address: ____

City, St Zip: ____

DOB: __________________ SS#: ______________________ M or F

Telephone Number: ____________________________________

INSURANCE / WC / PI INFORMATION:

Insured (circle): Self Spouse Child **Insured Name:**____________________________ **Insured SS#:**______________________

WC / PI Claim #:_______________________ **WC / PI Date of Injury:**__________________ **Dx Codes:** ____________________

Primary Insurance / Work Comp / Auto – Personal Inj.

Company: ______________________________________

Address: ______________________________________

City St., Zip: ______________________________________

Policy #:____________________ Group#: _________________

Adjuster: ______________________________________

Phone #: ______________________________________

Employer: ______________________________________

Secondary Insurance OR ATTORNEY INFORMATION

Company / Law Firm: ___________________________________

Address: ______________________________________

City, St., Zip:______________________________________

Policy #:____________________ Group#: _________________

Adjuster / Attorney Name:_______________________________

Phone # : ______________________________________

Fax #: ______________________________________

Credit / Debit Card Information (For Time-of-Service Payment Option)

VISA _____ MASTERCARD _____ DISCOVER _____ CARD NUMBER: ______________________________________

EXP. DATE: ___________ SECURITY CODE (3 digit on back) ______ ZIP: ___________ TOTAL AMOUNT PAID: $ ______________

CARDHOLDER SIGNATURE: ____

AUTHORIZATION OF SERVICES / RELEASE OF INFORMATION:

I understand that my imaging studies are being sent to Professional Imaging Consultants, Inc (PIC) for interpretation and written report by a board certified chiropractic radiologist. I understand that PIC will bill my insurance carrier and/or attorney for this service and that I am responsible for any unpaid balance (depending on insurance coverage). I authorize the release of my medical records to the insurance carrier and/or attorney. I also authorize that any payments from the insurance carrier and/or attorney be made directly to PIC. **I also understand that if I am covered by Medicare, MEDICARE DOES NOT PAY for these services.** A photocopy of this assignment will be considered as valid and effective as the original.

Patient Signature: ____ Date: ______________________

***If patient is a minor, indicate (circle) relationship to the patient*:** Mother Father Guardian Other: _________________

Chief Complaint: ____

Trauma, Cancer, Surgery? ____