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

BILLING INFORMATION FORM

Clinic / Doctor: _____

PATIENT INFORMATION (Complete For All Patients)

Name: _____

Address: _____

City, St Zip: _____

DOB: _____ SS#: _____ M or F

Telephone Number: _____

TYPE OF CASE

☐ Personal Injury ☐ Time of Service

☐ Cash ☐ 2nd Opinion

☐ Bill Doctor

INSURANCE / PI INFORMATION:

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

Claim #:_____ **Date of Injury:**_____ **Dx Codes:** _____

Primary Auto Insurance

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: VISA ___ MASTERCARD ___ DISCOVER ___

CARD NUMBER: _____ EXP. DATE: _____

SECURITY CODE (3 digit code on back) _____ ZIP CODE: _____ 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 if this is a Personal Injury (PI) case, PIC will bill my auto insurance carrier and/or attorney for this service and await payment. I authorize the release of my medical records to the auto insurance carrier and/or attorney of record. **I also authorize that any payments from the insurance carrier and/or attorney be made directly to PIC**. If I receive payment for services performed by PIC, I will forward the payment to PIC immediately. Ultimately, **I am responsible for any unpaid balance** (depending on insurance coverage). 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? _____