SCY Imaging, Inc.

Phone: 979-695-XRAY (9729)
FAX: 800-695-6382

Prescription and Referral Form

Patient Name ______________________ **Date** ______________
X-ray Number (for tech use) ______________________ **DOB** ______________
Medicare Charting? Y / N **M or F** ______________
Referring Dr. ______________________ Fax # ______________
Facility ______________________ Fax # ______________
Diagnosis ______________________________________

Exams Ordered: ______________ Number of Views: ______________

Portable Radiology is indicated for this patient due to:

_______ Geographical (rural) location, limited or no access to alternative source. Stationary unit unavailable.

_______ Physical limitations of Patient

- _______ Patient is non-ambulatory
- _______ Patient requires assistance with transfers
- _______ Patient is resident of Nursing Home
- _______ Patient is unable to drive
- _______ Other: ______________________

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Physician Signature

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Insurance Company to pay directly to SCY Imaging, Inc. benefits due me, if any, by reason of services described in t he statement rendered and are provided for in the above policy contract with aforementioned Insurance Company. I will be responsible for all such charges in excess of whatever sum may be paid by the Insurance Company above mentioned. I authorize the release of any medical information necessary to process this claim.

MEDICARE PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SCY Imaging, Inc., for any services furnished me by that service. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related services.

______________________ ______________
Patient Signature Date