Littrell Radiology

Radiology Consultation Services

PO Box 484
Wilton, IA 52778
Business (563) 650-6797

Patient's Name: ______________________________ DOB: ______________ Gender: M / F

Doctor's Name: ______________________________ NPI: ______________________

Chief Complaint: ____

Patient's Previous or Current Diagnoses, Surgeries, Traumas, Cancers: ______________________________

____

Is this result of a motor vehicle accident, personal injury, or work place injury? (Y/N) __________ Date: __ / _____ / _____

Do you have a particular region of concern on the radiographs? If so, indicate: ______________________________

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Date of Radiographic Examination: ____________________ Do you need a verbal report? (   )________________________

Doctor's Email Address: ________________________ (Reports will not be emailed; a secure web folder will be set up)

Billing: Littrell Radiology does not bill the patient's insurance for the professional component of interpretation (-26). Fees have been substantially reduced to offer affordable and accurate radiographic interpretations for physicians and patients, allowing greater time for image interpretation and less time for billing. The referring physician may bill and collect from the patient's insurance for the global charge of both the professional and technical components (-TC).

Choose one billing option: __________Payment enclosed   __________ Invoice the physician for all interpretations once/month

Patient Consent and HIPAA Statement:
I understand my referring physician requests my radiographs interpreted by Tracey A. Littrell, BA, DC, DACBR, DACO, CCSP®, a chiropractic radiologist certified by the American Chiropractic Board of Radiology. I am aware I will be responsible for this service and accordingly I hereby authorize Tracey A. Littrell and/or Littrell Radiology assignment of benefits for services rendered directly from my insurance carrier or attorney. Accordingly I authorize Tracey A. Littrell and/or Littrell Radiology 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 within forty-five days of the service will be my responsibility. **This service is not covered by Medicare.**

Patient's/Guardian's Signature: ________________________________ **Date:** ____________________

Referring Doctor's Signature: ____

LITTRELL RADIOLOGY CONSULTATION SERVICES NPI: 1942410659

	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3 v	$25.00		73030-26	Shoulder 2 v	$25.00		73630-26	Foot 3v	$25.00
	72050-26	Cervical 4 v	$25.00		73080-26	Elbow 2-4 v	$25.00		71010-26	Chest 1v	$25.00
	72052-26	Cervical 6 v	$25.00		73100-26	Wrist 3v	$25.00		71020-26	Chest 2v	$25.00
	72070-26	Thoracic 2 v	$25.00		73120-26	Hand 3v	$25.00		72010-26	Full spine 2v	$100.00
	72100-26	Lumbar 2v	$25.00		73510-26	Hip Uni 2v	$25.00				
	72110-26	Lumbar 4-5 v	$25.00		73560-26	Knee 1v	$25.00				
	71101-26	Ribs 3V	$25.00		73562-26	Knee 3v	$25.00				

Please call 563-650-6797 with any questions or concerns. We look forward to serving you and your patients.