

Littrell Radiology

Tracey A. Littrell, D.C., D.A.C.B.R.

PO Box 1235
504 Maurer Street
Wilton, IA 52778
(563) 650-6797

Patient Information

Patient's Name: _____ Gender: _____ Date of Birth: _____

Referring Doctor: _____ NPI: _____

Chief Complaint: _____

Area of concern on the radiographs: _____

Previous Diagnoses, Surgeries, Trauma, Cancer: _____

Date of Radiographic Examination: _____

Would you like a verbal report (please indicate phone number and best time to call) _____

Would you like the report sent to an email address? (please give only HIPAA-compliant email) _____

Bill doctor's office

Bill insurance

Payment enclosed

If Littrell Radiology will bill the patient's insurance company or other 3rd party payer, submit a copy of the insurance card/documentation or please complete:

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone () _____ Date of Birth: _____ / _____ / _____ SS#: _____

Patient's Employer: _____ Work Phone () _____

Primary Insurance Company: _____

Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone () _____

Policy No: _____ Claim No: _____

Group/Plan _____

First Insured's Name _____

SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Relationship: Spouse Child Other _____

Insured's Employer: _____

Related To Employer? Accident? Date: _____ / _____ / _____ State: _____

Attorney: _____

Attorney's Address: _____

Attorney's Phone () _____

Patient Consent

I understand that this office will have my radiographs interpreted by Tracey A. Littrell, D.C., D.A.C.B.R., a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and I accordingly hereby authorize Tracey A. Littrell, D.C., D.A.C.B.R. and Littrell Radiology assignment of benefits directly from my insurance carrier or attorney for services rendered. Accordingly, I authorize Tracey A. Littrell, D.C., D.A.C.B.R. 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.
Please note that this service is not covered by Medicare.

Patient's/Guardian's Signature: _____ Date: _____

Referring Doctor's Signature: _____