

# Littrell Radiology

**Radiology Consultation Services**

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

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F

Referring Doctor: \_\_\_\_\_ NPI: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Previous Diagnoses, Surgeries, Traumas, Cancers: \_\_\_\_\_

Region of Concern on Radiographs: \_\_\_\_\_

Date of Radiographic Examination: \_\_\_\_\_ Verbal Report Needed? ( ) \_\_\_\_\_

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

**Choose One:**       Payment Enclosed       Bill Patient's Insurance       Bill Doctor's Office

**Submit Insurance Card / Documentation OR Complete the Following:**

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Adjustor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Group/Plan: \_\_\_\_\_

First Insured's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship:  Spouse     Child     Other \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Related to Employment:  Accident?       Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ State: \_\_\_\_\_

Attorney: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Patient Consent:**

I understand that this office will have my radiographs interpreted by Tracey A. Littrell, BA, DC, DACBR, a radiologist certified by the American Chiropractic Board of Radiology. I am aware that 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											
√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE	√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3 v	\$40.00		73030-26	Shoulder 2 v	\$40.00		73630-26	Foot 3v	\$40.00
	72050-26	Cervical 4 v	\$40.00		73080-26	Elbow 2-4 v	\$40.00		71010-26	Chest 1v	\$40.00
	72052-26	Cervical 6 v	\$40.00		73100-26	Wrist 3v	\$40.00		71020-26	Chest 2v	\$40.00
	72070-26	Thoracic 2 v	\$40.00		73120-26	Hand 3v	\$40.00		72010-26	Spine, entire	\$100.00
	72100-26	Lumbar 2v	\$40.00		73510-26	Hip Unil 2v	\$40.00				
	72110-26	Lumbar 4-5 v	\$40.00		73560-26	Knee 1v	\$40.00				
	71101-26	Ribs 3V	\$40.00		73562-26	Knee 3v	\$40.00				
											<b>Total Due: \$</b>

For Office Use: Diagnosis Codes 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_