DIAGNOSTIC X-RAY CONSULTATION SERVICES®

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PATIENT AUTHORIZATION AND ASSIGNMENT

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I understand that all charges from this consultation are ultimately my responsibility and separate from any charges at my Physician's office.

I authorize the release of any medical information necessary to process this claim. I also authorize the direct payment of medical benefits from group health, medical payments or third party payor to the physician for services described above. In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay collection agency fees up to a maximum of 21% of the outstanding balance at the time the account is placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court cost incurred for collection.

Date_____ **Patient's Signature** _____
(Parent or guardian if minor child)

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the x-ray examination of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated_____ **Patient's Signature**_____
(Parent or guardian if minor child)

Patient's Name_____
(Please print)

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said doctor named above.

Dated_____ **Attorney's Signature**_____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.