# Strehlow Radiology Consultation Requisition

## Patient Information & Past Medical History

☐ MVA ☐ Acute Injury ☐ Insidious Onset ☐ Other

☐ Malignancies ☐ Surgeries ☐ Congenital Anomalies

Patient Name ( Please print clearly ) ☐ Female ☐ Male

Patient's Home Address

City, State, Zip Code

Social Security Number

Home Phone Number

Patient Date of Birth

Date of Injury

## Billing Information

_____ Referring Physician

☐ Attorney ☐ Insurance ☐ Physician ☐ Patient

See attached paperwork ☐ Past Medical History ☐ Billing

Name of Attorney / Insurance Carrier

Address of Attorney / Insurance Carrier

City, State, Zip Code

Insurance Policy Number

Accident Claim Number

Name of Adjuster

Adjuster's Phone Number

AN INFORMED CONSENT: To insure the highest quality of interpretation, the services of Strehlow Radiology Consulting, LLC, are being utilized to obtain a secondary opinion on my x-rays or other advanced imaging study. I understand that there is a separate fee for this service and that this fee may be billed directly by SRC. In accordance with the Medicare Act, this is to advise you that this is a non-covered service.

RELEASE OF INFORMATION: I do hereby authorize the above doctor / consultant to obtain from and to furnish to my physician, attorney, and or insurance carrier a full report of my case history, examination, diagnosis, and prognosis in regard to my accident and / or illness.

DOCTORS LIEN: I do hereby give a lien to the above doctor / consultant on any settlement, claim, judgment, or verdict as a result of the accident and or illness, and authorize and direct you, my attorney / insurance carrier to pay directly to the said doctor / consultant (Strehlow Radiology Consulting, LLC @ 141 W. Brigham Rd., Suite B - St. George, UT 84790) such sums as may be due and owing him for the services rendered me, and to withhold such sums from the settlement, claim, judgment, verdict as may be necessary to pay said doctor / radiology consultant. **I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SAID DOCTOR / CONSULTANT FOR ALL CHIROPRACTIC - RADIOLOGY BILLS SUBMITTED BY HIM FOR SERVICES RENDERED ME**, and that this agreement is made solely for said doctor / consultant additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover. I further agree never to rescind this agreement and instruct my attorney that any attempted rescission on my part shall be null and void. I also agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify the said doctor / Strehlow Radiology Consulting of any substitution of counsel or changes in my home address.

SIGNATURES & COPIES: I do hereby grant power of attorney to the said doctor / consultant for the discrete sole purposes of signing two-party checks received in the Strehlow Radiology Consulting, LLC name and or when dual signatures are required for payment on a check from an insurance company, and with the signing privilege related to insurance benefit applications in lieu of habeas corpus and forms related to the stated injury for which services have been rendered to facilitate the completion of insurance for processing the claim. I do hereby state and agree that a photocopy or facsimile of this document will be as valid and binding on all parties involved as the original document.

Patient / Guardian Signature Date

The undersigned, being the attorney of record or an authorized representative for the above patient does hereby acknowledge this lien and does agree to honor the same to protect adequately said above named doctor / Strehlow Radiology Consulting, LLC

Attorney Signature Date


STREHLOW RADIOLOGY CONSULTING

1-800-330-0772 Fax: (435) 674-2588

Billing & Records
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Suite 250
N. Las Vegas, NV 89031

Reading Office
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