Shield
Radiology Consultants Requisition

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## PATIENT INFORMATION & 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

☐Attorney ☐Insurance ☐Patient ☐Referring Physician

See Attached Paperwork ☐Past Medical History ☐Billing

Name of Attorney or Insurance Carrier

Address of Attorney or Insurance Carrier

City, State, Zip Code

Insurance Policy Number | Accident Claim Number

Name of Adjuster | Adjuster's Phone Number

**INFORMED CONSENT:** I understand and agree that the services of Strehlow Radiology Consulting, LLC, dba Shield Radiology Consulting ("SRC"), are being used to provide a secondary review and interpretation of my x-rays or other advanced imaging study for the purpose of determining the extent of any damage, diagnose and/or to determine the best course of treatment. I understand that there is a separate fee for this service and that all costs for services may be billed by SRC. In accordance with the Medicare Act, this is to advise you that this is a non-covered service.

**RELEASE OF INFORMATION:** I hereby authorize the SRC to obtain from, and to furnish to, my physician, attorney, and/or insurance carrier a full report of my case history, medical records, examination results, diagnosis, and prognosis as they relate to my accident, claim, treatment or illness.

**DOCTORS LIEN:** I hereby expressly grant to SRC a lien on any settlement, claims, judgments, verdicts or proceeds whatsoever arising from my accident or illness. I further expressly instruct, authorize and direct my attorney and insurance carrier to pay directly SRC at Shield Radiology Consulting, LLC, 168 N. 100 E., Suite 102 – St. George, UT 84770 all sums due and owing SRC for the services rendered to me or on my behalf, and to withhold such sums from any settlement, claim, judgment, verdict as are necessary to pay the same. I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SRC FOR ALL CHIROPRACTIC OR RADIOLOGY BILLS SUBMITTED BY SRC FOR SERVICES RENDERED TO ME OR ON MY BEHALF, and that this agreement is made solely for SRC's protection and to insure payment. I expressly acknowledge and agree that payments for services to SRC are not contingent on any recovery, settlement, claim, judgment, or verdict being recovered by me. I understand and agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify SRC of any change in counsel/attorney or changes in my home address.

**SIGNATURES & COPIES:** I hereby authorize SRC as my attorney-in-fact for the purposes of signing any two-party checks received by SRC any time payment is made in the form of a two-party check or when dual signatures are required for payment of services from an insurance company or third party payer. I do hereby warrant and agree that a photocopy or facsimile of this document will be as valid & binding on all parties involved as the original document.

Patient Signature or Guardian Signature Date

Referring Physician or Office

Being the Attorney of record or an authorized representative for the above named patient does hereby acknowledge this lien and does agree to honor the same to protect adequately Shield Radiology.

Attorney Signature or Authorized Representative