Denver Integrated Imaging

ACCIDENT INFORMATION

SECTION 1

Is this appointment related to an accident? (Circle one)

YES If yes, please complete sections 1, 2 and 3

NO If no, please complete only sections 2 and 3

SECTION 1 (please check one only if this exam is related to accident)

_____WORK
Please give a brief description below of what happened

_____AUTO
Please give a brief description below of what happened

____HOME
Please give a brief description below of what happened

____OTHER
Please give a brief description below of what happened

BRIEF DESCRIPTION:

_____

_____

_____

NAME OF PRIMARY INSURANCE: _____

SECTION 2 (TO BE COMPLETED BY ALL PATIENTS)

Medical Records Consent:
I authorize this facility to release any medical records to my physicians, third party payers, including but not limited to insurance companies, worker's compensation and other parties. I authorize the doctor ordering this exam to release medical records related to this exam to this facility.

INITIALS: _____ DATE:_____

SECTION 3 (TO BE COMPLETED BY ALL PATIENTS)

ASSIGNMENT OF BENEFITS:

I AUTHORIZE AN IRRECVOCABLE ASSIGNMENT OF BENEFITS, TO BE PAID DIRECTLY TO THIS FACILITY UNDER SAID INSURANCE POLICIES INCLUDING MAJOR MEDICAL BY REASON OF SERVICES RENDERED THEREIN. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION WILL SERVE THE SAME PURPOSE AS THE ORIGINAL.

PATIENT'S PRINTED NAME:_____

PATIENT'S SIGNATURE: _____
PARENT OR GUARDIAN (IF PATIENT IS A MINOR) _____