

Professional Imaging Consultants, Inc.

Edward J. Dailey, DC, DACBR
4680 Douglas Circle N.W.
P.O. Box 36952
Canton, OH 44735
(330) 498-9445 (800) 939-6900
(330) 498-9447 FAX

Dear Patient:

Your chiropractic physician is sending your x-rays to Professional Imaging Consultants, Inc. for interpretation and written report by a board certified chiropractic radiologist. Once the report is completed, the x-rays and report will be sent back to your doctor. Professional Imaging Consultants is a separate and distinct entity from your chiropractic physician’s office. Therefore, unless otherwise indicated, we will submit a separate bill for the services we render.

Your chiropractic physician is an expert in the diagnosis and conservative treatment of neuromusculoskeletal conditions. The chiropractic radiologist is an expert in diagnosing abnormalities from your x-ray, MRI’s or CT scans. The use of a separate specialist to interpret your x-rays helps to enhance the quality of the chiropractic care you will receive. If you have any questions, you may direct them to your doctor or you may call us at 1-800-939-6900.

Thank you
Professional Imaging Consultants, Inc.

Authorization of Services / Release of Information

I understand that my x-rays are being sent to Professional Imaging Consultants, Inc. (PIC) for interpretation and a written report by a board certified chiropractic radiologist. I understand that PIC will bill my insurance carrier and I or attorney for this service and that I am responsible for any unpaid balance. I authorize the release of my medical records to PIC and I authorize PIC to release my medical records to my insurance carrier and/or attorney. I also authorize any payments from my insurance carrier and/or attorney be sent directly to PIC. **I also understand that if I am covered by Medicare or United Healthcare, neither pays for these services and I agree to pay \$15 at the time of service for the reading of these x-rays.** A photocopy of this assignment will be considered as valid and effective as the original.

Patient / Guardian (sign here):

_____ Date: _____

If Guardian, please indicate relationship to patient: (e.g. mother, father, etc.)
