Munyeong Choi, DC, DACBR

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PATIENT CONSENT (This form is for third party billing)

Referring Doctor:_____ Date of Study:_____

Patient's name:_____ ☐ Male ☐ Female DOB:____/____/____SS#:_____

Patient's Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ or Cell phone:_____

PRIMARY INSURANCE NAME & BILLING ADDRESS

Patient's Employer:_____ Work phone #:_____

Name of Insurance Company:_____

Address:_____ City:_____ State:_____Zip:_____

Policy #:_____Claim #:_____Group/Plan:_____

Primary Insured's Name:_____ SS #:_____

Address (if different from the patient's address): _____

City:_____ State: _____ Zip: _____

DOB:____/_____/____ Relationship: ☐ Spouse ☐ Child ☐ Other: _____

Insured's Employer:_____

Patient Consent:
I understand that this office will have my radiographs interpreted by Munyeong Choi, D.C., D.A.C.B.R., a chiropractic radiologist certified by the American Chiropractic Board of Radiology. I understand that I am financially responsible for all charges for this imaging interpretation service and accordingly I hereby authorize Munyeong Choi Imaging Consultation to submit claims to my insurance company, workers compensation carrier, attorney, or other third party payer on my behalf. Accordingly I authorize Munyeong Choi Imaging Consultation

- To obtain information necessary to secure payment of benefits
- Authorize the use of this signature on associated benefit submissions.
- Authorize the release of any medical information necessary to process this claim.

If my insurance company, workers compensation carrier, or attorney denies partial or all payment on my behalf, I understand that I am financially responsible for any remaining balance.

Patient/Guardian Signature:_____ Date:_____