Brookside Radiology Consultants, Inc.
P.O. Box 349
Buzzards Bay, MA 02532
Phone: 508-743-5691
Fax: 774-302-4713

X-Ray Assignment Agreement and Consent

I understand that this office will have my X-Rays interpreted by John R. Henry DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize **Brookside Radiology Consultants, Inc. (BRC, Inc.)** assignment of benefits for services rendered directly from my insurance carrier or attorney. Therefore, I authorize **BRC, Inc.** to obtain information necessary to secure payment of benefits and **authorize the use of this signature** on associated benefit submissions. I also authorize the release of any medical information necessary to process the claim. Any amounts owed but not allowed will be my responsibility. Furthermore, I acknowledge that I have reviewed, with my doctor, and understand and agree to the Notice of Privacy Practices of **BRC, Inc.**

This Service is Not Covered by Medicare

_____ _____
Print Name Patient Signature

_____ _____
Today's Date Parent/Guardian Signature

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Age: _____ Sex: M F

To be completed by office staff:

Referring Doctor: _____ Date of Films: _____

Clinical Concern: _____

Comments: _____

_____

X-Ray Studies Submitted: _____