



Phone: 866-608-4DSD (4373) \* Fax: 214-853-5478

Dear Patient:

Your doctor is sending your x-rays to **D.S.D.** to obtain information that will help provide you with better patient care. **D.S.D.** will send reports about you to your doctor in the form of Pathology, Biomechanical, and Mensuration analyses. **D.S.D.** is a laboratory with specialized equipment, which provides over 500 different mathematical calculations used to construct and display 59 different diagnostic analyses of your spine.

Our Radiologist will review your x-rays and will carefully analyze all data, which your doctor considers when rendering your diagnosis and recommending a treatment plan based on your individual needs for faster recovery.

Radiographic Mensuration objectively documents the significance of the presence or absence of spinal injuries caused by trauma. This analysis measures the degree of spinal injury, very accurately. The process produces a precise graphical representation of your spine. This will enhance your understanding of your existing spinal problems and may correlate spinal instability with some of your symptoms.

**It is important for you to give your consent to the following items:** ( Initial a. through d.)

a. Release intl. \_\_\_\_\_

I understand my x-rays and other pertinent information relating to my treatment will be presented to **D.S.D.** for analysis. I further understand: (1) the sole purpose of this analysis is to obtain numeric measurements and graphical data pertinent to identifying Spinal injuries, Biomechanical abnormalities and Pathology analyses; (2) this information is valuable in order to assist my doctor in his/her evaluation of an initial treatment plan, as well as modifications to this plan during the course of treatment.

b. Insurance Assignment intl. \_\_\_\_\_

I authorize direct payment of medical benefits by all responsible insurance companies to **D.S.D.** I also authorize the release of any medical information necessary to process this claim. Should my current insurance policy prohibit direct payment to providers, I will direct my insurance company to issue a check payable jointly to **D.S.D.** and myself. I grant **D.S.D.** my power of attorney to endorse any checks made payable in my name, individually and/or jointly. A copy of this authorization shall be deemed valid as the original. If I have not met my deductible, it will be my responsibility to pay the amount still owed.

c. Assignment of Legal Rights intl. \_\_\_\_\_

If for any reason my insurance company denies payment for the **D.S.D.** procedure, I authorize the release to **D.S.D.** any and all medical review documentation that led to the denial. I irrevocably assign my legal rights to **D.S.D.** to act on my behalf to secure payment of this claim.

d. Attorney Lien intl. \_\_\_\_\_

I, hereby, irrevocably authorize my attorney to make payment in full to **D.S.D.** out of any eventual verdict or settlement. I am also notifying my attorney not to take any actions, as my representative, in any way to compromise or reduce the charges due **D.S.D.**. I will direct my attorney to sign the **D.S.D.** letter of protection regarding my charges. Upon issuance, I hereby agree that such letter of protection cannot be revoked or modified without the expressed written consent of this office.

e. Liability intl. \_\_\_\_\_

I do fully realize and understand that I remain personally responsible for services performed by **D.S.D.** on my behalf. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **D.S.D.** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees. All accounts will accrue interest charges @12% annually.

I have read the above and authorize the foregoing to be carried out on my behalf.

Patient's Signature: X \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

(Please Print)

Treating Doctor: \_\_\_\_\_

(Please Print)

Attorney Signature: X \_\_\_\_\_ Print \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I, the above signed Attorney do hereby agree to withhold the amount owing **D.S.D.** from any settlement, judgment or verdict and agree to pay **D.S.D.** for medical services which were provided to the above signed client.