



X-RAY Waiver

Your Physician may order an x-ray or supplies for you during your visit today. If so, you will receive a separate billing statement from Boulder Center for Sports Medicine. **You may incur an additional x-ray co-pay or the charges may be applied to your outpatient hospital deductible, which may or may not have been met by now.** Please let us know if you have any questions.

(PLEASE PRINT)

Today's Date: _____ Physician: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Phone # _____ SS # _____

INSURANCE

Policy Holder: _____ Date of Birth: _____ SS# _____

Policy Holder's Relation to You: _____

If you are a **student**, please provide the following:

Parent's Name: _____
Address: _____
City/State/Zip _____
Phone Number: _____

If your injury is due to an Auto Accident or a Worker's Compensation, please complete the following:

Date of Accident: _____
Claim #: _____ Insurance: _____
Adjuster: _____ Phone #: _____

X-Rays – If x-rays are requested and I have my x-rays performed here, I am responsible for these charges as well. X-rays may be applied to an outpatient hospital deductible. I will either supply my insurance information to the front desk **or** I will pay for these x-rays in full at the time of service (discounts may apply if payment is made in full at the time of service). I understand that I cannot submit my charges to any insurance company **if** I receive a self-pay discount.

Signature: _____ Date: _____

(This waiver is good for multiple dates of service pertaining to the diagnoses being treated at the time this waiver was signed, and the duration of treatment for these diagnoses.)