MONUMENT 9A IMAGING & DIAGNOSTIC CENTER

FILM OR DISC

PATIENT NAME: ________________________________

DOB: __________________ DOS: ____________________

TYPE OF STUDY: ________________________________

DATE REQUESTED: ______________________________

DATE NEEDED: _________________________________

PT ACCT # __________ PT PHONE # ______________

BY SIGNING THIS FORM, YOU UNDERSTAND THAT IF THESE FILMS NEED REPRINTED; THERE WILL BE A CHARGE OF $10 PER SHEET AND $5 FOR A NEW CD. (THIS DOES NOT APPLY TO XRAY FILMS DUE TO THESE BEING YOUR ORIGINAL FILMS). THESE ARE TO BE KEPT IN YOUR POSSESION AND NOT RETURNED TO OUR FACILITY UNLESS ABSOLUTLEY NECESSARY (AGAIN, EXCLUDING XRAYS).

SIGNATURE: _____________________ DATE: ___________

WHERE FILMS ARE BEING TAKEN TO: __________________