Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237 425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

Motor Vehicle Accidents

Patient name	Date
Responsible person	Date of injury

Insurance Information	
Name of insurance company	
Insurance company address	Phone number
Claim number	

I, _____, understand that I have been referred for a Radiology exam as a result of a Motor Vehicle Accident.

I further understand that Teton Radiology Diagnostics LLC, is unable to guarantee that any part of these services for the above patient will be covered by any insurance carrier. Accordingly, I, _____ (patient or responsible party), agree to personally pay Teton Radiology Diagnostics LLC for all services that are not paid within 60 (sixty) days, after being billed to the insurance carrier(s).

Signatures		
Patient/Guardian signature	If guardian, print name	Date
Responsible party signature		Date
Witness signature	Witness name (please print)	Date