

Physician Information

Name (First, Last) _____
NPI # _____
Healthcare Facility _____
Address _____
City, State, Zip _____
Phone Number _____
Email(s) _____

VirtuOst Test Information

Type of Test (choose one): **BCT** **BCT with VFA**
Reason for Testing _____
ICD Diagnostic Code(s) _____
Other Info _____
If spinal fusion pre-op, planned UIV level _____

Should OND provide a professional medical interpretation?

YES *(California patients only)* **NO** *(Physician will arrange)*

CT Scan Information

Should OND retrieve the CT scan from the Radiology Facility?

YES *(Fill out the information below)* **NO** *(Physician will mail CT Scan to OND)*

Radiology Facility _____
Address _____
City, State, Zip _____
Phone Number _____
Type of CT Scan _____
Scan Date (mm/dd/yyyy) _____

Patient Information

Male Female

Name (First, Last) _____
Patient ID / MRN _____
DoB (mm/dd/yyyy) _____
Address _____
City, State, Zip _____
Phone Number _____
Email _____

Payment & Insurance (check one option)

Bill Medicare (Part B) — Attach a copy of both sides of patient's Medicare (and any secondary) insurance card

Self-Pay — OND will bill the patient for all services rendered (OND will not file any reimbursement claim)

Patient Authorizations

Overall Consent: I request, consent, and authorize O.N. Diagnostics, LLC (OND) to perform the *VirtuOst* diagnostic test as ordered and determined medically necessary by the healthcare professionals involved in my care.

Assignment of Benefits & Financial Responsibility: I authorize OND to bill my insurance/health plan and furnish them with my *VirtuOst* order information, test results, or any other information requested for reimbursement. I assign all rights and benefits under my insurance plans to OND, who I authorize to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursement to be paid directly to OND in consideration for services performed. I understand I am responsible for any amount not paid by insurance, including any copays or deductibles and any amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. If self-paying, I agree to pay OND for all services rendered.

Use and Disclosure of Protected Health Information (PHI): I authorize an electronic copy of my CT scan to be released to OND for performing the *VirtuOst* test as part of my medical care. I understand my CT scan may contain sensitive information.

Patient Rights: This authorization for PHI is valid for one year from my signature and may be revoked by my written request to the Radiology Facility or to OND. I have the right to receive a copy of this authorization. I understand California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law.

Signatures (required for Physician and Patient)

Physician _____

Date of Order (mm/dd/yyyy) _____

Physician Certification: I am a licensed healthcare provider authorized to order the *VirtuOst* test, which I consider to be medically necessary for this patient. I will maintain the privacy of the test results and related information as required by HIPAA. I authorize O.N. Diagnostics to coordinate with any of its co-providers and/or the patient to retrieve the CT scan, perform the test, and arrange for any relevant billing or reimbursement.

Patient * _____

Date (mm/dd/yyyy) _____

Patient Authorization: By signing this form, I agree to all authorizations above, which I have read and understand.

* If signed by patient's legal representative, describe relationship to patient:

Fax the completed form to O.N. Diagnostics at (877) 554-0688 or mail it to the address shown above.