**Marion Chiropractic Center**

PO Box 1647

123 S. Chestnut St. Suite 106

Marion, VA 24354

276-706.8530

**Please let us know how you intend to pay for your health care. (Check one)**

**\_\_\_\_\_ (Check) \_\_\_\_\_ (Health Insurance) \_\_\_\_\_ (Auto Insurance)**

**\_\_\_\_\_ (Cash) \_\_\_\_\_ (Workman’s Compensation)**

**Insurance Assignment**

Before Dr. Miller can provide you with services, it is important that all financial arrangements are clearly understood. Our agreement for your health care is with you alone. Your insurance company is not a part of this agreement.

Since policy benefits vary from company to company and from policy to policy within each company, you are advised that you may or may not be fully compensated under the provision of your own insurance policy. Please note the carrying of insurance by us is done as a courtesy to our patients.

If payment is not received from your insurance company within a reasonable amount of time, forty-five (45) days from date of filing; you are responsible for payment of your account total. Be assured that insurance will be filed promptly. While insurance claims are being processed, your co-insurance payment is expected weekly.

Sincerely,

Heith A. Miller, DC

We cannot render services on the assumption that charges will be paid by an insurance company.

We request that services at the time of initial visit be paid in full.

I understand that all charges not covered by my insurance company, regardless of reason, are my full responsibility.

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