**Marion Chiropractic Center**

P. O. Box 1647

Marion, VA 24354

276-706-8530

**MEMBER BILLING ACKNOWLEDGEMENT**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a patient being treated by**

**Marion Chiropractic Center, LLC**

**Do hereby acknowledge that a certain portion of my care may not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with:**

**Name of Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand and agree to be responsible to self-pay for the following procedure should my insurance company deem as non-covered:**

**Chiropractic Manipulation - $ 35.00 Charge**

**X-ray - $100.00 Charge**

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**Member Signature**

**(Guardian must sign for all members 17 years or younger)**

**Member Health Plan ID Number**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**