

**Authorization for Payment**

Patient's Name \_\_\_\_\_

I authorize \_\_\_\_\_ to pay directly:  
Insurance Company

**Virginia Family Chiropractic & P.T. , PLLC**

344 Maple Avenue West #231

Vienna, VA 22180-5612

The expense benefits allowable, and otherwise payable to me under any insurance company toward the total charges for professional services rendered by this clinic.

**Release of Information**

I authorize this clinic to release any information pertinent to my case to any insurance company/adjustor/attorney/other doctor or healthcare provider. I hereby release this Clinic of any consequences thereof.

**Financial Responsibility**

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible; co-payment and any services and/or charges rejected and/or not paid in full by my insurance company. If outside collection services or attorneys are employed by this facility for the individual who disregards our office policies, he/she agrees to pay those charges, including court costs, attorney fees of 25% occurred in collection for services rendered.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: Parent or guardian of patient under 18 years old of age must sign.