

ASHBURN VILLAGE CHIROPRACTIC
44110 Ashburn Shopping Plaza, Suite 158
Ashburn, VA 20147
(703) 723-6800

PATIENT INFORMATION
UPDATE 20_____

Name _____
Last Name First Name MI

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (O) _____

Sex M F Age _____ Birth Date _____ SS# _____

Marital Status S M W Sep D

Email address _____

Patient Employed by _____

Business Address _____

Notify in case of emergency _____ phone _____

INSURANCE

Person responsible for account _____
Last Name First Name MI

Relation to Patient _____ Birth Date _____ SS# _____

Insurance company _____ Phone _____

ID# _____ Group# _____

AUTHORIZATION

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payments of the benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Patient agrees that if his/her account is sent to collection, then patient will be responsible for Ashburn Village Chiropractic's costs of collection, including attorneys' fees in the amount of 25% of the principal amount outstanding.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.