Authorization To Bill MEDPAY

I ________________________________(print name) do hereby give full permission and authorize Completely Natural Chiropractic, PC to bill my MEDPAY for services rendered me. I also agree that if possible, to have any checks from such services payable and deliverable to:

COMPLETELY NATURAL CHIROPRACTIC, PC
9778 Gayton Rd.
Richmond, VA 23233

By signing this document I also agree to the following statements below:

I understand that MEDPAY is a separate medical benefit rider attached to my automobile insurance. This covers my health care bills when I am involved in an automobile accident that has caused health-related problems for which I will receive treatment. I also understand that there are generally monetary limits to how much will be paid from such rider.

I understand that MEDPAY is NOT my health insurance. I also understand that any monies received via a 3rd party insurance carrier (i.e. Other driver's auto insurance carrier) are separate from MEDPAY monies.

For the purpose of this injury, I understand that Completely Natural Chiropractic, PC is utilizing my MEDPAY policy, NOT my health insurance as the primary source of payment for services rendered me.

I understand that I am responsible for obtaining information about my MEDPAY policy and providing such information to Completely Natural Chiropractic, PC for correct billing. Such information may include *name of company, billing address, contact person and financial benefits and/or limits to such benefits.*

I understand that Completely Natural Chiropractic, PC will be providing services and billing my MEDPAY for those services at various times during the course of my chiropractic treatment. I also understand and give permission for Completely Natural Chiropractic, PC to bill my MEDPAY before my health insurance for the payment of care and services rendered me.

I understand that because MEDPAY works as a contractual relationship between my auto insurance carrier and myself, Completely Natural Chiropractic, PC's bills will be paid to me and in my name. **I further understand that when I receive such checks from my MEDPAY, that I shall bring them into Completely Natural Chiropractic, PC's office within 5 business days so that said payment can be applied towards my balance due for care rendered me.**

I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Completely Natural Chiropractic, PC's office during my care. This means that before I pay any other parties, including other medical doctors, medical facilities, lawyers and myself from any settlement, that I must first pay Completely Natural Chiropractic, PC in full for services rendered me for care at this office.

The undersigned does agree to observe and abide by all of the statements made above.

______________________________________ ____________________
Patient's Signature Date

______________________________________ ____________________
Witness Signature Date