Certification and Assignment

I certify that I, _____ and/or my dependent(s), have insurance coverage. I assign directly to **Dr. Jonathan Chiropractic & Acupuncture** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether to be paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Jonathan may use my healthcare information and may disclose such information to the Insurance Company(s) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Our full notice of Privacy Practices is posted in our office and available from the front desk receptionist. Please read it carefully. If you have any questions or require additional information, please contact the office manager who can assist you at 540-672-2506

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Dr. Jonathan Chiropractic & Acupuncture
149 Belleview Avenue Orange, VA 22960
(540)672-2506 phone (540)308-7899 fax

Patient #_____