

CHIROPRACTIC  
NEUROLOGY  
CENTER

9302 N. Meridian Street, Suite 170  
Indianapolis, IN 46280

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original
- I understand that there will be a \$25 charge to my account for not canceling appointments within 24 hours.

Name (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_