Miller Chiropractic Clinic

Dr. William A. Miller, D.C.P.A.
2201 E. 25th St., Suite U
Lawrence, Kansas. 66047

AUTHORIZATION TO PAY DOCTOR

I HEREBY AUTHORIZE _____
(Insurance Company)
To pay by check made out to and mailed directly to:

Dr. William A. Miller, D.C.P.A.
Miller Chiropractic
2201 W. 25th St., Ste U
Lawrence, KS. 66047

the expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above mentioned assigned. I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

_____
Date

_____
Print Name

_____
Address

_____
City, State, Zip

_____
Signature