## **CONSENT TO BILL INSURANCE**



I authorize the release of any information to my insurance company when necessary to process my claims.

I also authorize payments under my insurance to be made directly to the providers for any services furnished.

I understand my insurance company will be billed on my behalf and I am responsible for any copayments and deductibles.

I agree that if my treatment is not covered by my insurance policy, I will be responsible to the provider for the entire amount.

I certify that the following information is true and correct to the best of my knowledge and will notify SHBHI of any changes of my insurance the following information.

## Patient's Name

First Name	Last Name	
Primary Policy Holder's Name	Date of Birth	
Patient/Parent Signature		_

Date

140 E. Commonwealth Ave., Suite 101 Fullerton, CA 92832 Phone (714)773-4111 Fax (714)774-4222

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