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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