CONSENT TO BILL INSURANCE

Sunny Hills Medical Center
Urgent Care . Primary Care
Behavioral Health

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

_____