Billing Consent Form

I authorize the release of any medical information necessary to process claims related to this procedure.

I recognize that I am responsible for whatever amounts of the bill for services rendered, up to the entire amount, that the insurance does not cover such as any co-pay or deductible.

I also understand that is it my responsibility as a patient to provide Star Surgical Suites with my currently active insurance information. If I provide you with the incorrect information, I will be responsible, and I will be billed for services rendered.

Thank you for your consideration and understanding in this matter.

PATIENT NAME: _____

SIGNATURE: _____

Date: _____