Permission to Bill Insurance

1. I give permission to [name of clinic or doctor’s office] to file for insurance benefits to pay for the care I receive.
2. I understand that:

* [name of clinic or doctor’s office] will send my medical information to my insurance company.
* I must pay my share of the costs.
* I must pay for the cost of the care I receive if my insurance company does not pay or I do not have insurance.

1. I understand:

* I have the right to say not to any treatment or procedure.
* I have the right to discuss all medical treatments with my provider.
* I have the right to ask about costs before I am treated.

Patient’s Signature Date

Parent or Guardian Signature Date

(for children under 18)