Authorization to Bill Insurance

Patient: _____ Guardian (if Minor):_____

Phone: _____ Email: _____

Address: _____

Insurance Company: _____ Policy: _____

Doctor: _Dr. Starcevic_____ Office: Star Cardiology Care PC_____

Phone: 908-923-4499_____ Location: 403 Route 202, Suite 200_____

Flemington, NJ 08822-6037_____

I, the undersigned, hereby certify and attest that I have sought evaluation, or medical advice from the staff at the office named above. I therefore authorize the medical staff and personnel to release my medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

_____ _____

Signature Date