

# Harmony Heals, Inc



## Insurance Information & Assignment of Benefits

**Please Print**

**Male**

**Female**

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone (Hm)

\_\_\_\_\_  
Phone (Wk)

\_\_\_\_\_  
Phone (Hm)

\_\_\_\_\_  
Phone (Wk)

Marital Status: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Employment: Full Time\_\_\_\_ Part Time \_\_\_\_\_

Full Time\_\_\_\_ Part Time \_\_\_\_\_

Student \_\_\_\_\_ Unemployed \_\_\_\_\_

Student \_\_\_\_\_ Unemployed \_\_\_\_\_

Employer: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

\_\_\_\_\_

Insured By: \_\_\_\_\_

\_\_\_\_\_

Insurance Phone: \_\_\_\_\_

\_\_\_\_\_

Membership # \_\_\_\_\_

\_\_\_\_\_

Referral I.D. \_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_

\_\_\_\_\_

Policy # \_\_\_\_\_

\_\_\_\_\_

If coverage is for a dependent, (Last Name, First Name) \_\_\_\_\_;  
(Date of Birth) \_\_\_\_\_; and by which policy dependent will be covered \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO HARMONY OF BODY, MIND & SPIRIT AND/OR THERAPISTS OR ASSISTANTS FOR SERVICES RENDERED.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

