

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 HEALS, INC AND/OR THERAPISTS, PSYCHIATRIST, CHIROPRACTOR OR ASSISTANTS FOR SERVICES RENDERED.

Signature _____ Date _____

Address _____ City/State/Zip _____

Witness _____ Date _____

24351 Moulton Parkway Suite # 120 Laguna Woods, Ca. 92637
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