Harmony United Psychiatric Care

Consent for Insurance Filing

This is a required form that must be completed for service

I authorize (1) release of any information my Provider may feel necessary to process my insurance claims and (2) payment of benefits directly to my Provider of services.

I fully understand that I am responsible for any portion of my bill not covered by my insurance company including, but not limited to, co-payments, deductibles, etc.

I understand and provide my consent for insurance filing.

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Signature of Client/ Patient or Parent/ Legal Representative Date