

Harmony Family Health

Daniel J. Chartrand, MD

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404 North Church Street
McKinney, Texas 75069

Insurance Claims Information

Patient Information:

Name: _____

Patient Status (Check all that apply) Single _____ Married _____ Other _____
Employed _____ Full-time Student _____ Part-time Student _____

Patient Relationship to Primary Insurance Holder (Check one)
Self _____ Spouse _____ Child _____ Other _____

Primary Insurance Holder Information: (If different than patient)

Name: _____

Date of Birth: _____ Sex: M _____ F _____

Address: _____

Telephone: _____

Insurance Card Information:

Insurance Plan Name: _____

ID Number (please print clearly): _____

Policy Group Number (please print clearly): _____

Claims Address: _____

I authorize the office of Dr. Daniel J. Chartrand to file my insurance claims electronically and to release any medical or other information necessary to file these claims.

I understand that I am responsible for any payments to Harmony Family Health at the time of service. Insurance reimbursement rates are dependent upon my insurance plan for out-of-network providers. Any payments from my insurance company will be directed to me.

Primary Insurance Holder's Signature _____ Date: _____