INSURANCE AGREEMENT

HRC Behavioral Health & Psychiatry, PA
100 Europa Drive
Suite 260
Chapel Hill, NC 27517
(919) 929-1227

Patient: _____

Provider: _____

I understand I am responsible for payment in full for the services rendered because:

_____ I have requested my insurance carrier not be billed for these services.

_____ Provider does not participate with my insurance. Upon receipt of my payment in full HRC will provide the necessary forms for my insurance carrier to reimburse me.

_____ The service rendered by above provider is not covered by my insurance plan.

My signature indicates I have read and agreed to the terms above. I accept the responsibility for payment in full.

Patient/Guardian: _____ Date: _____

Witness: _____ Date: _____