Clinic: Towers Audiology Center
8631 W Third St. #312E
Los Angeles, CA 90048
(310) 652-4327 Fax (310) 652--7900

Date:

PERSONAL INFORMATION

Name
Mr./ Ms. First M Last

Address
House Number Street Name Unit Number

City State Zip DO NOT send any print mailings

Date of Birth
mm/dd/yyy
Gender Female Male

Email DO NOT email special offers DO NOT email for any reason

Home phone Mobile phone DO NOT text Work phone

Marital status Occupation

ALTERNATE CONTACT INFORMATION- Optional

Name Is primary contact
First MI Last

Address

City State Zip Use alternate contact for billing

Relationship to patient

Email DO NOT email for any reason

Home phone Mobile phone DO NOT text Work phone

PRIMARY INSURANCE INFORMATION

Insurance Company name

Insurance ID no.

Insurance group no.

Primary subscriber
Last name, First name
Gender Female Male

Date of birth Relationship to patient

Address of subscriber if different than patient
Street address

City State Zip

Subscriber phone if different than patient

SECONDARY INSURANCE INFORMATION

Insurer name | Gender | Female | Male

Insurance ID no. | Relationship to patient

Insurance group no.

Date of birth

Address of subscriber if different than patient | Street address

City | State | Zip

Subscriber phone if different than patient

REFERRAL INFORMATION

Who referred you or how did you find out about us?

Primary Care Physician | Clinic Name

By checking this box, I consent to having my medical test results and findings shared with the referring physician

PATIENT HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from insurance or third party benefit plans;
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

INSURANCE AND PAYMENT

I authorize the clinic to provide medical treatment and file my insurance and third party benefit claims. I authorize payments of medical benefits to be paid directly to the clinic. I accept full responsibility of all services and charges not paid for by my insurance company or third party benefit plan.

I accept full responsibility for all charges in the event that I have no insurance or third party benefits. Charges 30 days past due are subject to late fees.

PATIENT SIGNATURE

(You Must Allow Pops Up to Sign Form)

Patient signature or legal custodian