LAS CRUCES HEARING CENTER
2525 S. Telshor Blvd. Suite 110
Lac Cruces, NM 88001-5062
505-521-1416
800-786-4131

Patient Information

Please take a moment to complete the following information. Thank you.

Today's Date		☐ M ☐ F	☐ New ☐ Update
Name		Date of Birth	
Parent/Guardian		Social Security #	
Address			
City	State	Zip Code	
Phone: Home	Work	E-Mail	
Whom may we thank for referring you?			
Who is your regular Doctor?			

Billing Information

Third Party payment requires prior authorization for most services provided by our staff. Please contact the office manager for more specific information

I have the following type(s) of insurance:	Insurance company Information
☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Self Pay ☐ Other	Policy holders name Policy holders social security # Policy Holders Date of Birth Policy number Name of insurance company Address of insurance company Telephone # of insurance co.

Assignment and Release

☐ I authorize Las Cruces Hearing Center to obtain or release confidential information or records regarding the hearing health of the patient named above. This authorization will be valid for 180 days from the date indicated below.
Release to: _____

☐ I, the undersigned, have insurance coverage with _____ and assign directly to Las Cruces Hearing Center all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

☐ I request that payment of authorized medical benefits be made either to me or on my behalf to Las Cruces Hearing Center for any services furnished me by the audiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

☐ I have had the opportunity to review the Privacy Practices and understand that I may receive a copy.

Signature of Patient or Responsible Party	Date signed
Relationship to Patient	