ALBUQUERQUE
HEARING AND BALANCE

Insurance Information

(Please provide a copy of your insurance card and fill out this section completely)

Primary Insurance Plan ____________________________ Member Number _____________________________

Name of Insured_____________________________ Insured's DOB ____________________

Insured's SSN ___________________________________ Insured's Gender: M / F

Relation of insured to Patient (circle one): Self Spouse Parent Partner

Insured's Employer ______________________________________Work Phone ____________________

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Secondary Insurance Plan __________________________ Member Number ______________________________

Name of Insured_____________________________ Insured's DOB ____________________

Insured's SSN ___________________________________ Insured's Gender: M / F

Relation of Subscriber to Patient (circle one): Self Spouse Parent Employer Other

Insured's Employer ______________________________________Work Phone ____________________

Responsible Party
(if other than patient or if patient a minor)

Responsible Party Name ___________________________________ SS#_______________________________

Address____City/State/Zip_________________________

Telephone Number________________________ Relationship to patient (circle): Mother/Father/Legal Guardian

I authorize release of any information concerning my (or my child's) examination, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize insurance benefits, otherwise payable to me, to be paid directly to Albuquerque Hearing and Balance. I understand any services denied by the insurance carrier may be my financial responsibility as well as any copays, deductible and/or coinsurance as required by my insurance company. In addition, I authorize Albuquerque Hearing to send me marketing material and appointment reminder postcards via mail/email.

☐ **I have declined a copy of the HIPPA document**. ☐ **I have received a copy of the HIPPA document**.

AHB keeps PHI in secure electronic files. All PHI paperwork is kept in locked containers, then containers taken by an AAA NAID certified document destruction service and shredded on an industrial shredder.

_______________________ __________________ _________________

Signature Relationship to Patient Date