TORRANCE MEMORIAL URGENT CARE

22411 Hawthorne Blvd., Torrance, CA 90505
Phone: 310-784-3740 Fax: 310-375-1392

TORRANCE MEMORIAL PHYSICIAN NETWORK

Please print and complete all of the following fields. Please have your Driver's License, Insurance Card, and form of payment available before going to the front desk. Thank you!

PATIENT NAME

NAME OF PATIENT: LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDAY (MM/DD/YEAR)	SOCIAL SECURITY#:

ADDRESS:	CITY	STATE	ZIP CODE

SEX	PATIENT/LEGAL GAURDIAN HOME PHONE NUMBER	PATIENT/LEGAL GUARDIAN CELL PHONE NUMBER
M F	( ) HOME	( ) CELL

PRIMARY CARE PHYSICIAN (PCP):	RACE	PREFERRED LANGUAGE	ETHINICITY

PRIMARY INSURANCE INFORMATION

NAME OF SUBSCRIBER: LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDAY (MM/DD/YEAR)	SOCIAL SECURITY #:

NAME OF INSURANCE CARRIER	MEMBER ID #/ SUBSCRIBER #	GROUP #

ADDRESS OF SUBSCRIBER (IF DIFFERENT THAN ABOVE):	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE INFORMATION

NAME OF SUBSCRIBER: LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDAY (MM/DD/YEAR)	SOCIAL SECURITY #:

NAME OF INSURANCE CARRIER	MEMBER ID #/ SUBSCRIBER #	GROUP #

ADDRESS (IF DIFFERENT THAN ABOVE):	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT:

PHARMACY INFORMATION

NAME OF PHARMACY	ALTERNATE PHARMACY
ADDRESS OF PHARMACY	ADDRESS OF PHARMACY
CITY OF PHARMACY	CITY OF PHARMACY
PHONE OF PHARMACY	PHONE OF PHARMACY

LIST ALL CURRENT MEDICATIONS

LIST ALL ALLERGIES TO MEDICATIONS

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS FORM

I hereby assign and convey Torrance Health Association, as my designated authorized representative, all medical benefits and/ or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Torrance Health Association (THA), DBA Torrance Memorial Physician Network (TMPN) for any equipment or services. (i.e. provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand and agree:

- That I am Financially responsible to the organization for all charges regardless of any applicable insurance or benefit.
- It is my Responsibility to notify the organization of any charges in my heath care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill or balance of the bill as determined by the organization and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to THA/TMPN any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from THA or its attorneys in order to claim such medical benefits.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments on the services I receive.

_____	_____	_____
Patient/Beneficiary Name (Print)	Signature	DOB
_____	_____	_____
Patient/Beneficiary Name (Print)	Signature	DOB
_____	_____	_____
Parent/Guardian (Print)	Signature	Date