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.

_____ _____ _____

Signature Relationship to Patient Date