Mendocino Lake Audiology

756 South Dora St.
Ukiah, CA 95482
(707) 463-2966
Fax: (707) 463-2970

200 Lakeport Blvd.
Lakeport, CA 95453
(707) 263-9428
Fax: (707) 263-9427

Patient Information

Today's Date:_____ Referred By:_____ Email Address: _____

Patient's Name_____
First Middle Last

Mailing Address:_____
Street/PO Box Number City Zip

Home Telephone:_____ Work Telephone:_____

Occupation:_____ Employer:_____

Patient's Date of Birth:_____ Social Security Number:_____

Regular Family Doctor:_____
Name Phone

Spouse or Parent: _____
Name Phone

Emergency Contact: _____
Name Relation Phone

Insurance Information: Private___ Medicare___ Medi-Cal___
Other_____

Please provide the receptionist with a copy of ALL of your insurance cards.
Or provide the following:

Insurance:_____Person Insured:_____
Policy #_____Group #_____

Insurance:_____Person Insured:_____
Policy #_____Group #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Mendocino/Lake Audiology for services furnished to me by Glynis Tambornini, M.S., CCC-A. I authorize any holder of medical information about me, to release to Health Care Financing Administration (HCFA) and its agents, any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

In Medicare assigned cases, the physician 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 deductibles are based upon the charge determination of Medicare carrier.

I (print name) _____ am aware that my insurance may deny payment for today's medical service or procedure. I agree to assume full financial responsibility for the charges incurred.

Patient's Signature:_____Date:_____