# HENG MEDICAL INC.

500 PASEO CAMARILLO, SUITE 100, CAMARILLO, CA 93010 TEL: (805) 484 1033 FAX: (805) 482-7213

## PATIENT INFORMATION

***Referred by:*** _____

Patient Name: (First) _____ (M.I) _____ (Last) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Employer: _____

Sex: ☐Male ☐Female Date of Birth: ____________ **E-Mail Address**: _____

Phone: Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Marital Status: _____ Ethnicity: _____ Social Security #: _____

Primary Insurance Name & Policy#: _____ Secondary Insurance: _____

Emergency Contact (**#1**) _____ Relationship to Patient: _____
Phone: Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Emergency Contact (**#2**) _____ Relationship to Patient: _____
Phone: Home (_____) _____ Work (_____) _____ Mobile (_____) _____

I hereby consent that Heng Medical, INC. provide me with all the health care services that, at their discretion, is necessary for my treatment. I hereby authorize Heng Medical, INC. the release of any medical or other information necessary to the health plans, government agencies, attorneys, or their representatives for processing the claims. I hereby authorize the health plans, government agencies and attorneys to pay Heng Medical, INC. the medical and surgical benefits allowable as payment towards the total charges for medical treatment and services rendered. I understand that I am fully responsible for the charges resulting from treatment, which is not covered by this assignment, and pay them promptly. I am aware that upon using my health plan benefits for any services rendered by any out of network provider; I will be going out of network and exercising my "OPTOUT BENEFITS" choice. I certify that the information contained in this form is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that may have been made in completion of this form. I authorize the use of this signature on all insurance submissions. _____ **(INITIAL)**

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heng Medical, INC. for any services furnished to me by that physician. 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 for 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, my signature authorizes releasing of the information to 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. _____ **(INITIAL)**

***If you choose a paperless option, and choose to fill out the forms from your computer for email submission, adding a "forward slash" symbol before and after your typed signature denotes an accepted substitute for your written signature (example: /First Name Last Name/ ).***

**Patient's Signature** _____ **Date:** _____

**Parent/Guardian Signature (If Applicable):** _____