TORRANCE MEMORIAL
PHYSICIAN NETWORK

Torrance Memorial Urgent Care

☐ 2900 Lomita Boulevard
Torrance, CA 90505
Phone: 310-784-3740
Fax: 310-539-1006

☐ 855 Manhattan Beach Boulevard, Suite 101
Manhattan Beach, CA 90266
Phone: 310-939-7873
Fax: 310-939-7856

Please print and complete all of the following fields. Please have your driver's license and insurance card available before going to the front desk. Thank you!

Patient information

Patient name: Last name	First name	MI	**Date of birth** (MM/DD/YYYY):	
Address:	City	State	ZIP code	
Social Security #:	**Sex:** M F	**Patient/legal guardian home phone number:** ( ) Home	**Patient/legal guardian cell phone number:** ( ) Cell	
Primary care physician (PCP):	**Race:**	**Preferred language:**	**Ethnicity:**	

Primary insurance information

Subscriber name: Last name	First name	MI	**Date of birth** (MM/DD/YYYY):	
Social Security #:	**Name of insurance carrier:**	**Member ID #/Subscriber #:**	**Group #:**	
Address (if different than above):	City	State	ZIP code	**Relationship to patient:**

Secondary insurance information

Subscriber name: Last name	First name	MI	**Date of birth** (MM/DD/YYYY):	
Social Security #:	**Name of insurance carrier:**	**Member ID #/Subscriber #:**	**Group #:**	
Address (if different than above):	City	State	ZIP code	**Relationship to patient:**

By signing below, I hereby certify that to the best of my knowledge, all 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 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 of any applicable insurance or benefit.
- It is my responsibility to notify the organization of any charges in my healthcare 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	Date of birth
Parent/guardian name (print)	Signature	Date