Scarlet M. Aviles, Au.D.

Patient Information

Name: _____ _____ _____ Sex: M F
Last First M.I.

Mailing Address: _____ City, State, Zip _____

Birthdate: _____ Marital Status: S M W D SSN (last 4 digits): _____

Phone No: Home: _____ Work: _____ Cell: _____

Employer: _____ Occupation: _____

Referred by: _____ Other: _____

Primary Care Physician: _____ Your Email: _____

Address or Responsible Party if different from above

Name: _____ _____ _____ Sex: M F
Last First M.I.

Birthdate: _____ SSN: _____

Address: _____ City, State, Zip _____

Phone No: Home: _____ Work: _____ Cell: _____

Employer: _____ Occupation: _____

Insurance Information

Primary Insurance: _____

Subscriber Name: _____ Birthdate: _____

Relationship to Patient: Self Spouse Parent Other: _____

Secondary Insurance: _____

Subscriber Name: _____ Birthdate: _____

Relationship to Patient: Self Spouse Parent Other: _____

Tertiary Insurance: _____

Subscriber Name: _____ Birthdate: _____

Relationship to Patient: Self Spouse Parent Other: _____

Emergency Contact

Relationship: _____

Name: _____ Phone No: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANIES

I hereby authorize Scarlet M. Aviles, Au.D. to release to my insurance company, or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, TRICARE, Private Insurances and any other health plan to Scarlet M. Aviles, Au.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges, devices and accessories whether or not paid by said insurance. I understand that I will be assessed a returned $15 charge for each check due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection and reasonable costs (minimum $20) attorney fees, as may be required, to effect collection of this issue. I hereby authorize assignee to release all information necessary to secure payment.

Signature: _____ Date: _____