TORRANCE MEMORIAL PHYSICIAN NETWORK

FOR USE BY PATIENTS 18 YEARS & OLDER

PATIENT REGISTRATION FORM

Patient Information

Patient's Last Name	Patient's First	M.I.	Patient DOB	Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown
Primary Language	Preferred Name		Marital Status	
Race: (check all that apply) ☐ White ☐ Black / African American ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander ☐ Decline to Answer ☐ Other_____				**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Patient's Street Address Apt #	City		State	Zip Code
Patient's Primary/Cell Phone ( )	Patient's Home Phone ( )		Patient's Day/Work Phone ( )	
Patient's E-mail Address	Patient's Social Security Number		Patient's Primary Care Physician	
Emergency Contact Full Name	Relationship		Home Phone ( )	Cell Phone ( )
Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Self-Employed ☐ Not Employed ☐ Retired Date: _____				
Patient's Employer Name	Employer Phone ( )		Patient's Occupation	
Employer Address	City	State	Zip Code	
Is there any other information you would like your physician to know? (e.g. language translator needed, preferred pronoun, blind or visually impaired, hard of hearing, etc.)				

Insurance Information

Primary Insurance Company	Member ID		Group#	
Subscriber's Full Name			Subscriber's Date of Birth	
Subscriber's Social Security#	Subscriber's Address			
Subscriber's Employer Name	Relationship to Patient	Subscriber's Employment Status ☐ Full Time ☐ Part Time ☐ Retired Date: _____		
Subscriber's Employer Address	City	State	Zip Code	Employer Phone ( )
Secondary Insurance Company	Subscriber's Full Name		Member ID	Group#
Subscriber's Date of Birth	Relationship to Patient		Secondary Subscriber Address	

Guarantor person responsible for the bill

Guarantor's Last Name	First	M.I.	Date of Birth	Relationship to Patient
Street Address	City		State	Zip Code
Home Phone ( )	Work Phone ( )		Cell Phone ( )	

Acknowledgement: By signing below, I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Torrance Health Association DBA Torrance Memorial Physician Network to provide any and all medical treatment to myself or my dependent.

_____ _____

Signature of Patient or Patient Representative Today's Date

Revised 06/01/2022

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge you have been provided our Notice of Privacy Practices.Our Notice of Privacy Practices tells you how we may use and disclose your protected health information. Signing this form does not mean you agree or disagree with our Privacy Practices.It simply means we have provided information about our Privacy Practices to you.

We may change our Notice of Privacy Practices from time to time. If we change our Notice, you canfind a copy of the new Notice on our website at tmphysiciannetwork.org or by contacting us. We will also keep a copy of the current Notice posted in our facilities.

If you have questions, please contact the Privacy Office:

Torrance Memorial Physician Network
23326 Hawthorne Boulevard, Suite 200
Torrance, CA 90505
Phone: 310-517-1165 ext. 71165

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and that I am authorized to attest to this as the individual or legal representative by my signature recorded electronically on the signature notepad.

Patient name (please print) _____ Patient / Patient Representative signature _____

If Representative, give relationship _____

Date (MM/DD/YYYY) _____ Time _____

STAFF ONLY:

If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain their acknowledgement, and the reasons why it was not obtained:

- ☐ Patient is unresponsive
- ☐ Patient is injured
- ☐ Patient refused
- ☐ Patient unable to sign/no family at bedside
- ☐ Other

(specify)_____

Staff name (please print) _____ Staff signature _____

Date (MM/DD/YYYY) _____ Time _____

TORRANCE MEMORIAL PHYSICIAN NETWORK **FOR USE BY PATIENTS 18 YEARS & OLDER**

FINANCIAL & ASSIGNMENT OF BENEFITS POLICY

We would like to thank you for choosing Torrance Memorial Physician Network for your healthcare. Please ask for clarification if needed, and sign in the space provided. A copy of this agreement will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the physician/provider.

Regarding Insurance Billing

You are responsible to provide accurate insurance information for covered healthcare services. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for payment in full. We will bill your insurance company as a courtesy. It is your responsibility to know your benefits and how they will apply to your treatment by the physician/provider. We do not have access to the details of your insurance policy.

Your co-insurance and/or unmet deductible is your financial responsibility. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or co-insurance, and service amounts. All co-pays will be collected at the time of service. If you are scheduled to have a surgical procedure you may be required to pay a deposit. Any deposits will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You may forfeit part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the physician's care team for further details regarding this deposit.

Form Fees

There is a fee (per form) for completing disability, insurance, and/or medical imaging copies. Payment is due when the form is completed. Please allow 5 business days to complete the form(s). For a full list of fees, please see receptionist.

Assignment of Benefits

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 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.

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 for all services that I receive.

Patient's Name (Please print) Date of Birth

Signature of Patient or Patient Representative Today's Date

Relationship to Patient

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION & CONSENT TO TREAT

Completion of this document authorizes the disclosure and/or use of your medical information. Failure to provide all information requested may invalidate this Authorization.

This Authorization is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Use and Disclosure of Health Information. I hereby authorize Torrance Memorial to release my Protected Health Information (PHI), by means of verbal communication in person, via telephone, mail, or facsimile to the following individuals:

Name: **Relationship:**

_____ _____

PLEASE USE ONE AUTHORIZATION PER INDIVIDUAL DESIGNEE

_____ _____
Patient Name Date of Birth

_____
_____ Today's Date
Patient Signature

This Authorization shall remain in effect unless and until which time it is revoked. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Torrance Memorial Physician Network
ATTN: Privacy Officer
23326 Hawthorne Boulevard, Suite 200
Torrance, CA 90505

Revocation. You have the right to revoke this Authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this Authorization, before the time you revoke it. The Revocation Form is available upon request.

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COMMUNICATION PREFERENCES & CONSENTS

Patient Name: _____ Date of Birth: _____

This form shall explain the different methods of communication a patient may choose from. It is important to note that not all communication preferences perform in the same manner.

MyTorranceMemorial Patient Portal is our primary method for confidential communication. This authorization allows you to have access to online appointment requests, to send messages to the office and online access to your medical information.

- ☐ Yes – Please communicate with me by secure email through the Patient Portal. **Please fill out the attached Proxy/Patient Portal form to sign up.** My email address is _____. I will let you know right away if my email address changes.
- ☐ No – Please do not communicate with me via the E-mail.

Texting. This authorization allows us to communicate through our Automated Appointment Reminder, Messaging and Survey System. By providing your cell phone number we will automatically enroll you in these systems.

- ☐ Yes – Please communicate with me by text message for reminders and surveys.
  My cell phone number is _____. I will let you know right away if my cell phone number changes.
- ☐ No – Please do not communicate with me by text message.

Voicemail. This authorization allows Torrance Memorial to leave voicemail messages at a designated phone number. To protect your confidentiality, we will not leave messages with your spouse, family members or any other individual unless you specifically give your permission in writing to do so, using the "Authorization for Use or Disclosure of Medical Information" form.

- ☐ Yes – Please communicate with me by private phone number.
  My phone number is _____. I will let you know right away if my phone number changes.
- ☐ No – Please do not communicate with me by private phone number.

Consent to Photography I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purposes of my diagnosis or treatment or for Torrance Memorial operations, including security, peer review, education, or training programs.

☐ Yes, I consent. ☐ No, I do not consent.

Disease Registries and California Immunization (CAIR) Registries are computer-based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals to assess needs and avoid redundant immunizations and control disease outbreaks. Torrance Memorial shares information with CAIR Registries. Additional information can be found at https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-updates-disclosure.aspx

Open Payments Database Notice. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov .

Revocation. You have the right to revoke authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this authorization, before the time you revoke it. A Revocation Form is available upon request.

I have read and acknowledge the information listed above.

Patient Name	Date of Birth
Patient Signature	Today's Date

TORRANCE MEMORIAL
PHYSICIAN NETWORK

Patient and Proxy Agreement for Use of MyTorranceMemorial

(Please print)

Patient's Name: _____ Date of Birth: _____
Last **First** **Middle** **(MM/DD/YYYY)**

Address _____
Street City State ZIP

Choose One:

__ I am already registered for MyTorranceMemorial at email address _____@_____

__ I would like to register for MyTorranceMemorial at email address _____@_____
(Non-work email recommended)

__ I do not want to have my own access to MyTorranceMemorial. I am only authorizing a proxy.

I authorize this person to be registered for MyTorranceMemorial as my proxy:

Proxy's Name_____ **Date of Birth** _____
Last First Middle MM/DD/YYYY

Female __ Male __ **Relationship to Patient** _____

Proxy's Address: _____
Street City State ZIP

Proxy's Email Address _____@ _____
(Non-work recommended)

I understand that MyTorranceMemorial is to be used only for routine matters. If I have an urgent issue or need a response quickly, I agree to call my health care provider.

I understand that the initial invitation to create an account will be sent to the above email address(es), and that notifications will be sent to the same email address(es) to announce incoming communications on MyTorranceMemorial. My proxy and I agree to update MyTorranceMemorial with any changes of email address(es).

I understand that my proxy, and I if I choose to register, will each choose our own unique user ID and password. My proxy and I will keep password(s) confidential, and not share them with anyone, because it allows access to **my** personal health information. If I choose to discontinue use of MyTorranceMemorial, or discontinue my proxy's access to my information, I understand that a written request is necessary. However, such a cancellation will not be effective as to uses or disclosures already made.

I have reviewed the above information and will abide by the Policy and MyTorranceMemorial Terms of use.

Signature of Patient **Date**

As proxy, I agree to all of the above statements for using MyTorranceMemorial on behalf of the patient.

Signature of Proxy **Date**

Please present a photo ID for both patient and proxy when submitting this form.

FOR OFFICE USE ONLY

Identity of Patient Verified By: _____ Patient's MRN_____
Identity of Proxy Verified By: _____

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