



Pediatric Intake Form

Patient's name: Last, First, Middle		Phone Numbers: Home:	
Address: City: State: Zip:		Cell:	
Mailing Address (if different):		Date of Birth:	Age:
Email Address:		Sex: M F	
<i>(Email will only be used for Hearing Associates purposes. It will not be sold or given to any other party. By providing your email address, you authorize Hearing Associates to send periodic newsletters and announcements. <input type="checkbox"/>PN <input type="checkbox"/>SS</i>			
Mother/Guardian: Address:		Phone (h):	Phone (w):
Father/Guardian: Address:		Employer:	
		Phone (h):	Phone (w):
		Employer:	
In Case of Emergency, Notify: Name:		Phone:	
Person Responsible for Account: Name:		Phone:	
Primary Care Physician: Name:	Address:	Phone:	
Whom may we thank for referring you: Name:		How did you hear about our office:	
List family members who are currently patients in this practice:			
Please list current medications and dosage (Some medication may affect hearing & balance):			
Please list allergies:			

Payment is due at the time of service. When you have insurance with hearing benefits, we are happy to submit the initial billing. Any necessary rebilling is your responsibility. I authorize the release of any information required for insurance and appropriate reports.

Signature

Date

By signing the front of this registration, you are confirming that you have read, understood, and accept the policies on the reverse side of this form.

Hearing Associates

BY SIGNING THE FRONT OF THIS REGISTRATION, YOU ARE CONFIRMING THAT YOU HAVE READ, UNDERSTOOD, AND ACCEPT THE FOLLOWING POLICIES OF HEARING ASSOCIATES.

With your permission, our office will be happy to bill your insurance company or provide the information to you so that you may bill them yourself. **We are not responsible for making sure your insurance company covers your charges or reimburses you. We recommend that if your insurance has not paid within 30 days of billing that you telephone your agent and inquire about your claim.**

We allow up to **60 days** for your insurance to pay your charges. Beyond this time, you are responsible for meeting your obligation.

Charges left unpaid beyond 60 days are considered overdue. A rebilling charge of \$10 per month is added to the overdue balance.

Unresolved accounts are considered to be delinquent after **75 days** from date of service.

FINANCIAL AGREEMENT:

BY SIGNING THE FRONT/PAGE ONE OF THIS REGISTRATION, I AGREE TO PAY ALL CHARGES INCLUDED ON THIS ACCOUNT IN ACCORDANCE WITH THE TERMS ABOVE.

RELEASE OF MEDICAL RECORD INFORMATION:

I hereby authorize Hearing Associates to release the files and medical records pertaining to me to my physicians and insurance companies **EXCEPT** as specified below:

EXCEPTIONS: _____

ASSIGNMENT OF INSURANCE BENEFITS

In the event that you bill my insurance, I hereby authorize payment directly to Hearing Associates. I understand I am financially responsible to Hearing Associates for all charges not covered by insurance. A **COPY** of this authorization shall be considered as effective and valid as the original.