acadianhearing

PEDIATRIC PATIENT INFORMATION

Name:_____ ☐ MALE ☐ FEMALE
First M. Last

Social Security # _____-_____-_____ DOB:_____/_____/_____ Age:_____

Primary Care Physician _____ Referring Physician _____

RESPONSIBLE PARTY *(PARENT OR GUARDIAN)*

Name:_____ Relationship to Patient:_____

Address:_____ Apt/Suite:_____

City:_____ State:_____ Zip Code:_____

Social Security # _____-_____-_____ DOB:_____/_____/_____ Phone: ( ) _____-_____

Home Ph. ( )_____-_____ Work Ph. ( )_____-_____ Cell Ph. ( )_____-_____

Occupation:_____ Email address _____

Marital Status_____ Spouse: _____

What is the birth mother's maiden name? _____

Other Legal Guardian (if applicable): _____ Relationship to pt:_____

INSURANCE INFORMATION

Please disclose **all** insurance coverage/policies. Failure to do so may result in charges becoming patient responsibility.

Primary Insurance:_____ Policy Holder: _____

Policy Holder's Birthdate: _____/_____/_____ Policy Holder Social Security #: _____-_____-_____

Secondary Insurance:_____ Policy Holder: _____

Policy Holder's Birthdate: _____/_____/_____ Policy Holder Social Security #: _____-_____-_____

INFORMED CONSENT AGREEMENT:

I understand that evaluation of the hearing/speech systems requires the use of specialized instrumentation. During the course of this evaluation, I understand that various earphones with be placed over or in my ears and various probes may be placed in the external ear canal. In the event amplification or other custom devices are required, I consent to placement of foam or cotton blocks in the external ear as well as, materials to make ear impressions.

I do hereby authorize Acadian Hearing Services to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to Acadian Hearing Services for professional services rendered.

I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT, AND OTHER AMOUNTS NOT COVERED BY MY INSURANCE COMPANY/COMPANIES. I/We agree to be bound by the above terms and conditions.

AS REQUIRED BY HIPAA ACT 1996, I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES FOR THIS PRACTICE AND A PAPER COPY IS AVAILABLE TO ME BY REQUEST.

Signed: _____ Date: _____