SOUTHSIDE HEARING CENTER

New Patient Intake Form

PATIENT INFORMATION					
DR. MR. MRS. MS. MISS *(circle one)*	PATIENT NAME			DATE OF BIRTH	GENDER
MARITAL STATUS	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	E-MAIL ADDRESS	
ADDRESS	CITY		STATE	ZIP	
EMPLOYER	WORK PHONE NUMBER	OCCUPATION (OR FORMER OCCUPATION, IF RETIRED)			
WHO MAY WE CONTACT IN CASE OF EMERGENCY?	RELATIONSHIP TO PATIENT		HOME PHONE NUMBER	OTHER PHONE NUMBER	
PRIMARY CARE PHYSICIAN	HOW WERE YOU REFERRED TO US?				

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION				
FATHER OR GUARDIAN'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME/CELL PHONE	WORK PHONE
MOTHER OR GUARDIAN'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME/CELL PHONE	WORK PHONE

AUTHORIZATION FOR TREATMENT: I authorize Southside Hearing Center to perform testing, care and management services relating to my hearing care needs.

PATIENT RESPONSIBILITIES: I understand that as the patient, parent or guardian, I am legally responsible for payment of all charges relating to my care. The patient and/or responsible party agrees to pay reasonable attorney fees and cost of collection if patient's account is placed in the hands of an attorney or collection agency for handling.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration (or their intermediaries, agents or carriers) and/or State in which I reside or its Fiscal Agents, or the insurance company or its representatives any information needed for this or a related Medicare or other insurance claim. In consideration of services rendered, I transfer and assign to Southside Hearing Center any payment which may become due to me for medical services under policies applicable to me or my dependent. The provider or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the **patient is responsible only for the deductible, co-insurance, and non-covered services**. Co-insurance and the deductible are based upon the charge determination of the insurance carrier.

FOR MEDICARE PATIENTS ONLY: I understand that Medicare will pay for a hearing evaluation ONLY if it is medically necessary and a physician referral has been made, and that they will NOT pay for a hearing evaluation if it is solely for the purpose of obtaining hearing aids. I have been informed that prior to any evaluations, I will need to obtain a script or order from my primary physician or an otolaryngologist (ENT) and provide it to Southside Hearing Center. If I do not provide a script/order, I understand that I will be asked to sign a Medicare Advance Beneficiary Notice (ABN), with the understanding that Medicare will most likely NOT pay for the evaluation, and I agree to pay the out-of-pocket cost for the evaluation if Medicare denies the claim for this reason.

PRIVACY NOTICE: By signing below, I acknowledge that I have been provided a copy of Southside Hearing Center's Notice of Privacy Practices, as well as the opportunity to designate specific parties with whom I would like to have my information shared.

_____ *(initials)*

MARKETING RELEASE: By initialing this section and signing below, I authorize Southside Hearing Center to send me educational and/or marketing information on the products and services they offer. No remuneration is involved in this communication. I understand that I may revoke this authorization in writing at any time.

_____ _____

Patient Signature (or parent/guardian if patient is a minor) Date

SOUTHSIDE HEARING CENTER IS NOT A MEDICAID PROVIDER.