Welcome

Pediatric Patient Intake

To be completed by parent or legal guardian

Please be sure to complete both sides

Patient Personal Information

Child's Name: _____ Date of Birth: _____ Gender: F M

Names of Parents or Legal Guardians: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Party Name: _____ Cell Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

Preferred method for appointment reminders: ❑ Text ❑ Email _____

How did you hear about us / Referred by: _____

Siblings (Names & Ages) at home: _____

Name of Child's School, Pre-School, or Child Care Setting: _____

Whom may we speak with regarding your child's care? _____

Please let us know to whom we may send a report of today's results:

Physician/Pediatrician: _____ Teacher/School Audiologist: _____

ENT or other specialist: _____ Other: _____

Insurance Information

Insurance cards will be copied for carrier information and ID#, however we do need the following:

Subscriber Name: _____ DOB: _____

Patient relationship to insured: Self ____ Child ____ Other ____

Secondary Insurance Subscriber Name: _____ DOB: _____

Patient relationship to insured: Self: ____ Child ____ Other ____

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company above and assign directly to Accent on Hearing, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. Delinquent accounts can be charged an interest rate of 1.5% of the unpaid balance and all costs incurred by Accent on Hearing, Inc., in collecting such payment, including attorney's fees and court costs. I hereby authorize Accent on Hearing, Inc., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature of person completing form Relationship Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that a copy of Accent on Hearing's Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice is available in the reception area and electronically on the website, www,accentonhearing.net. I may request a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Accent on Hearing will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Accent on Hearing may use and share my health information for other than treatment, payment, and healthcare operations.
- Accent on Hearing will also use and share my health information as required/ permitted by law.

_____
Printed name of patient or personal representative

_____
Signature of patient or personal representative

_____
Date