MAICO AUDIOLOGICAL SERVICES
Adult Intake Sheet

Today's Date: _____ **How did you hear about us?** _____

PATIENT INFORMATION

Patient's Name (as appears on insurance card) _____
(First) (Middle Initial) (Last)

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email address: _____ **Patient's Soc Sec #** _____

Date of Birth: _____ **Sex (circle):** M F **Marital Status (circle):** Single Married Other

Employment Status (circle): Full time Part time Not employed **Student Status (circle):** Full time Part time Not a student

PRIMARY INSURANCE INFORMATION: If patient is also insured, enter "SAME" for name and address

Insured's Name (as appears on insurance card) _____
(First) (Middle Initial) (Last)

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Patient Relation to Insured: Self Spouse Child Other **Insured Date of Birth:** _____ **Insured Sex (circle):** M F
(circle)

Insured Employment Status (circle): Full time Part time None **Insured Employer** _____

Insurance Co. Name: _____ **Insurance ID #:**_____ **Insurance Group #:**_____

OTHER INSURANCE INFORMATION: If patient is also insured, enter "SAME" for name and address

Insured's Name (as appears on insurance card) _____
(First) (Middle Initial) (Last)

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Patient Relation to Insured: Self Spouse Child Other **Insured Date of Birth:** _____ **Insured Sex (circle):** M F
(circle)

Insured Employment Status (circle): Full time Part time None **Insured Employer** _____

Insurance Co. Name: _____ **Insurance ID #:**_____ **Insurance Group #:**_____

PRIMARY CARE PHYSICIAN

Referring Physician _____ **Address** _____

PCP Telephone _____ **PCP Fax** _____

1. **Please provide a copy of all insurance cards.** 2. **All HMO patients, please provide a referral from your PCP prior to office visit.**
3. **All Medicare and Medicaid patients will need a prescription, or note, from their physician in order for us to bill their insurance.**

Please read and sign back.

Notice to Our Patients

- **All co-pays and deductibles are due at time of service.**
- **We will gladly file all insurances for our patients if we receive proper information. After a 60-day wait, the bill then becomes your responsibility.**
- **We do not arbitrate any denials, that is expressly between you and your insurance company.**
- **All payments for supplies are due at time of purchase.**

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of information necessary to process claims and request payment be made directly to Maico Audiological Services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Maico Audiological Services will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Maico Audiological Services will be credited to my account upon receipt.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further agree in the event of nonpayment to bear the cost of collection, and/or court costs and reasonable legal fee, should this be required.

AUTHORIZATION TO RELEASE INFORMATION TO THE FOLLOWING:

Name: _____ **Address** _____
Name: _____ **Address** _____
Name: _____ **Address** _____
Name: _____ **Address** _____

My signature below acknowledges that I have read and agree to abide with the above information.

Signature:_____ **Date:**_____

For Office Use Only:

____ **Notice of Privacy Practice**
____ **Copy of all Insurance cards**
____ **Confirmation of eligibility**
____ **Referral (make copy for billing clerk; original in chart)**
____ **Data Entry of Patient Information**
____ **Data Entry of Insurance Information**
____ **Data Entry of Appointment**
____ **Organize and file chart accordingly**