MAICO AUDIOLOGICAL SERVICES
Child 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)

Parent(s)/Guardian(s) Names____

Address____

City ________________________ State ______________ Zip Code ________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Guarantor's Soc Sec # ______________ Date of Birth: ______________ Sex (circle): M F

Student Status (circle): Full time Part time None

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 (circle) Insured Date of Birth: ______________ Insured Sex (circle): M F

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 (circle) Insured Date of Birth: ______________ Insured Sex (circle): M F

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. If child is with a HMO, please provide a copy of referral from your primary care physician before each visit.
3. If a school has referred you, please provide a copy of school referral.

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