SOUND HEARING
AUDIOLOGY & SPEECH
50 Hazelwood Drive
Jericho, NY 11753
P: (516) 932-7577
F: (516) 252-5131

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name: ________________________________ First Name: _________________________________

Date of Birth: _____________ Gender: ______ Marital Status: ___________ Occupation: __________________

Address: ____

City: _____________________ State: ______ Zip: __________ Primary Phone: (   )_________________ ☐ HOME ☐ CELL

Nickname: ______________________ Email: ____

Would you like to receive appointment reminders and follow-up messages by text/email? ☐ Text ☐ Email ☐ No

Emergency Contact Name: ___________________________________ Relationship to Patient: __________________

Primary Phone: (   )_________________ ☐ HOME ☐ CELL Opt in as primary contact method for the patient? ☐ Yes ☐ No

Address: ____

INSURANCE INFORMATION

Primary Insurance: ____________________________ ID #: ____

Name of Insured: _____________________________ Relationship to Patient: ________________________

Date of Birth of Insured Member: _______________

Secondary Insurance: __________________________ ID #: ____

Name of Insured: _____________________________ Relationship to Patient: _________________________

Date of Birth of Insured Member: _______________

PHYSICIAN INFORMATION

Primary Care Physician: _________________________________ Phone: (   )_____________________

Address: ____

PATIENT RESPONSIBILITY/HIPAA ACKNOWLEDGEMENT FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that l am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
   - Co-payments are due at the time of service.
   - If my plan requires a referral, I must obtain it before my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided
   - If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT BENEFITS**
   - I hereby authorize and direct payment of my medical benefits to **SOUND HEARING AUDIOLOGY AND SPEECH** on my behalf for any services furnished to me by the providers.

3. **MEDICAL REQUEST FOR PAYMENT**
   - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in **SOUND HEARING AUDIOLOGY AND SPEECH**. I authorize any holder of medical or other information about me to be released to Medicare and its agents any information needed to determine these benefits for related services.

4. **AUTHORIZATION TO RELEASE RECORDS**
   - I hereby authorize **SOUND HEARING AUDIOLOGY AND SPEECH** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me, needed to substantiate payment for such medical services, as well as information required for precertification, authorization or referral to other medical providers.

5. **ELECTRONIC COMMUNICATION CONSENT**
   - I understand that communication via email or text may not be fully secure. I consent to receiving messages through these channels for scheduling and follow-up purposes.

6. **HIPAA PRIVACY ACKNOWLEDGEMENT AND DISCLOSURE**
   - I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices, which explains how my medical information may be used and disclosed.
   - I consent **SOUND HEARING AUDIOLOGY AND SPEECH** to the use and disclosure of my protected health information (PHI) upon request for treatment, payment, and healthcare operations, as permitted by HIPAA.
   - I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it.

____ ____________________

Signature of Patient, Authorized Representative, or Responsible Party Date

____ ____________________

Print Name of Patient, Authorized Representative, or Responsible Party Date