**PATIENT INTAKE FORM**

Patient Name: Sex: M F\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MI LAST

Date of Birth: / / Age Marital Status: S M D W\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY CIRCLE ONE

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET Apt# CITY STATE ZIP

Home Phone: Cell Phone: Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: Current or Former Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like to be contacted? Ο Home Phone Ο Email Ο Cell Phone Ο Mail

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom may we contact?

Name: Phone Number: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we release medical information to this person? Y N

I**N ORDER FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU, THE FOLLOWING MUST BE SIGNED:**

I authorize the release of any medical and/or other information necessary to process my medical claim. Further, I authorize payment of medical benefits to be made directly to Upper Peninsula Audiology, INC for services rendered**. Submitting my claim to my insurance provider does not guarantee their payment. I accept responsibility for co-pays, deductibles, or uncovered procedures**. This authorization shall remain in effect until otherwise stated in writing, by myself.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/PARENT/ GUARDIAN SIGNATURE DATE

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize Upper Peninsula Audiology, INC to release any and all medical information in the course of my (or my child’s) treatment to the primary care physician listed above. In addition I would like to have this information forwarded to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/PARENT/GUARDIAN SIGNATURE DATE

**CONSENT FOR TREATMENT**

I consent to receive audiological services at Upper Peninsula Audiology, INC. The consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent for will be valid and remain in effect as long as I receive audiological care at Upper Peninsula Audiology, INC.

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PATIENT/PARENT/GUARDIAN SIGNATURE DATE

**I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices.** \_\_\_\_\_\_\_\_\_ INITIALS