Ear Works AUDIOLOGY
The Sound Choice For Better Hearing.

Pediatric Intake Form

Last Name: _____ **First Name:** _____

Sex: Male / Female **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: (____)_____-_____**Email:** _____

Ok to email?: YES NO **Ok to text?:** YES NO

Referred by: _____

Reason for Testing: _____

Name/Address of Pediatrician: _____

Has the child ever to been to this center? Yes / No

Parent/Guardian: _____

Address (if not same as above):

_____

Insurance: _____ **Policy Number:** _____

Group Number: _____ **Relationship to Insured:** _____

Policy Holder: _____ **Policy Holder DOB:** _____

Policy Holder Address (if not same as above): _____

Policy Holder Employer: _____ **Employer's Phone Number:** _____

Employer's Address: _____

Do you suspect any hearing loss?	YES	NO	POSSIBLY
Does your child have any history of ear problems?	YES	NO	
Does your child have any history of developmental delays?	YES	NO	
Does your child receive any therapies/services?	YES	NO	

If yes, please list: _____

Does your child take any medications? YES NO

If yes, please list: _____

Does your child have any significant medical problems? YES NO

If yes, please explain: _____

Name of hospital where your child was born: _____

Were there any complications with the pregnancy and/or delivery? YES NO

If yes, please explain: _____

Was your child in the NICU? YES NO

If yes, please explain: _____

Is there any family history of hearing loss? YES NO

If yes, please explain: _____

Has your child ever experienced any of the following?

- **Ear Infections** YES NO
- **Drainage from ear** YES NO
- **E.N.T. surgery** YES NO
- **Tonsils and/or Adenoid problem(s)** YES NO
- **Cerumen (wax) problem** YES NO
- **Imbalance or dizziness** YES NO

Please list any additional information that would be useful for our evaluation:

_____

_____

_____

_____

_____

_____

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As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Ear Works Audiology, P.C. to send/give my medical information as noted:

Leave a voicemail recording including my Personal Health Information on my home/cell phone: ☐ Yes ☐ No

Leave a voicemail recording including my Personal Health Information on my business phone: ☐ Yes ☐ No

Use of electronic communications (i.e. email, fax, electronic messaging) to transmit prescription, Treatment, disorder related information, lab or other results: ☐ Yes ☐ No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ☐ Yes ☐ No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: ☐ Yes ☐ No

Name of Personal Representative: _____

On this date _____ I received and reviewed Ear Works Audiology, P.C. 's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered. ☐ Yes ☐ No

The authorizations made above will remain effective until such time as I notify Ear Works Audiology, P.C. in writing, be certified mail, of requested changes.

_____ _____
Patient Signature Date

_____ _____
Patient Phone Number Date of Birth

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FINANCIAL POLICY

Thank you for choosing Ear Works Audiology, P.C. as your hearing healthcare provider. The following is a statement of our financial policy which we require that you read and sign prior to any service. Any patients must complete our information and insurance form before being seen.
FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS WE ARE PARTICIPATING WITH YOUR INSURANCE CARRIER.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AND DISCOVER.
****There will be a $30.00 charge for any returned checks.**

Patients with participating Insurance coverage:
All co-pays, deductibles, referrals and/or pre-certification/authorization numbers are expected at the time of service. Please be aware that even though we may be a participating provider in your insurance plan, all services may not be covered. Therefore, verification of coverage does not mean payment in full. If your insurance company does claim that they provide 100% coverage of hearing aids, then you may be limited as to the level of technology that you may obtain.

Patients with non-participating Insurance coverage:
Where we do not participate with your insurance carrier or your insurance coverage has been denied, you are ultimately responsible for payment in full. Your insurance company is a contract between you and your insurance company. We are not a party to that contract. If you have out-of-network benefits, then you may request that we submit the billing to your insurance company. We then may choose to accept assignment of benefits upon verification of your insurance coverage. Please be aware that in cases where we accept what the insurance will pay there may still be co-pays and/or deductibles that you will be responsible to pay. If your insurance company has not paid your account in full within 45 days, you will be held responsible for the payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the terms of the policy.

Usual and Customary Rates:
Our practice is committed to providing the best service for our patients and we charge what usual and customary for our area. Where we are a participating provider and payment is provided for a hearing aid purchase, and then we are only able to provide you with the level of technology that is considered reasonable and customary by your insurance plan (which is usually entry level digital). Where we are a non-participating provider, you are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Minor Patients:
A legal guardian must accompany all minor patients. The legal guardian is responsible for full payment.

Patients Signature: _____ **Date:** _____

Legal Guardian's Signature (if applicable) : _____