PANHANDLE MOBILE AUDIOLOGY CLINIC

PATIENT INTAKE FORM

Date: _____

Patient: _____
First Name Middle Initial Last Name

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Age: _____ Date of Birth: _____ **Please Check:** Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

SS # of Patient: _____ Responsible Party (if minor) Parent/Guardian: _____

Referred by: ☐ Friend/family member ☐ Social media ☐ Online search ☐ TV or print ad ☐ Other: _____

Family Doctor (Pediatrician, etc.): _____

Primary Insurance: _____ Patient's Place of Employment: _____

Name of Insured (Insured = **Primary Policy Holder,** i.e., parent, spouse, etc.): _____

Social Security #: _____ Date of Birth: _____ Relation to Patient: _____

Policy #: _____ Group Number: _____

RELEASE OF INFORMATION:**

I hereby authorize members of the staff to release my information to the following. Please check **all** that apply:

☐ Referring Physician ☐ Spouse ☐ School

☐ Referring Facility (i.e., ECI, DARS, etc.) ☐ Parent(s) ☐ Employer

☐ Family Doctor ☐ Child(ren) ☐ Insurance Company

☐ Other: _____

The staff may leave a message at _____ and/or _____ regarding an appointment or receipt of durable medical equipment.

**Per HIPAA (Health Insurance Portability and Accountability Act) legislation, we cannot give your information to anyone not authorized on this list. A complete outline of HIPAA compliance information for this office is available and may be requested at the front desk. We will file with your insurance after each visit. Although the test(s) have been deemed medically necessary by the referring physician, in the event that insurance does not pay, you are responsible for the remainder of the bill. Please note, if we are not authorized to send additional requested information to your insurance company, this may delay the process of your claim.

I have read the above information and understand my rights under the HIPAA legislation. I also understand that my insurance coverage does not guarantee payment to Amarillo Hearing Clinic.

_____
Signature

5501 SW. 9th Ave., Amarillo, TX 79106
(806) 726-7622 | www.panhandlemac.com