New Patient Intake Form NEWBORN HEARING TESTING

Patient Legal Name:_____ Preferred Name: _____
Date Of Birth:_____ Newborns due date: _____
Patient is: Male / Female (circle)
Birth Place (Name of hospital or birth center):_____
Mothers full Name: _____
Fathers full Name:_____
Mothers Social Security Number: _____
Fathers Social Security Number: _____
Primary Mailing Address: _____
Primary Phone: _____ Secondary Phone: _____
Preferred Email: _____
Primary Care Physician: _____ Primary Care office: _____
How did you hear about our office? _____
Please list **ALL** of your insurance carriers here: Primary: _____ Secondary: _____
Tertiary: _____*note: **all** insurance **MUST** be listed in the space above, no exceptions
****Name of Policy Holder**: _____
****Policy holder's Date Of Birth**: _____ relationship to client: _____

PATIENT History (please fill out the following history on the patient who is to be seen):

Were there any complications during the mothers pregnancy? If no please list here: _____
_____
_____
_____
_____
_____
_____

Is there a known family history of hearing loss (in children)? If yes please elaborate here:
_____
_____
_____

Does this newborn have any siblings? Yes (how many?) _____ No

Please list all medical procedures and medications that have been administered to this newborn: _____
_____
_____
_____
_____
_____
_____
_____

Please list here anyone who you authorize, in addition to your PCP or referring physician and DHEC /Firstsound, to receive a report of our findings:

_____

_____

_____

HIPAA Notification: By signing below you acknowledge a copy of Palmetto SpOTs Notice of Privacy Practices was provided to you. This notice provides information about how we may use and disclose you protected information; we encourage you to review it carefully. Further information about the notice may be obtained by contacting our privacy office at admin@palmettospot.com. I give permission to SpOT to correspond with legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that once SpOT email is sent externally, correspondence may potentially be intercepted by an outside party.

Legal signature of or on behalf of patient _____ Date: _____

Health Insurance Benefits / coverage / authorizations DISCLAIMER- MUST READ AND SIGN:

As a courtesy Palmetto SpOT (legally listed as Palmetto Hearing Care Center, LLC) will attempt to verify your health insurance benefits, and / or obtain necessary authorizations for your services. Please be aware, this is only a *Quote* of your healthcare benefits provided to us by your insurance company but is *not a guarantee of payment*. *We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service.* We file insurance as a courtesy to our patients.

In most cases, your insurance will only pay for services that it determines to be reasonable and necessary. Our office will make every effort to bill your insurance company in a timely manner. If your carrier determines that a particular service is not reasonable and/ or necessary, or that a particular service or diagnosis is not covered under your plan, your insurance will deny coverage for the service and the billed charges will become your responsibility.

We strongly recommend, request and encourage you to be familiar with, and verify, your own benefits with your insurance company prior to being seen in our office. Please also be aware of any deductible amounts that may interfere with your out of pocket expenses for services.

I understand that Palmetto SpOT will bill my insurance company. I understand that all co-pays are due on the date of service. I understand that I am responsible for all deductible and co-insurance amounts that will likely be billed to me after an EOB is received after services are rendered. I understand that it is my financial responsibility to pay the balance due within 30-days of receiving the bill. If my insurance company denies service, I am aware and agree that I am financially responsible for my entire balance due.

Legal signature of or on behalf of patient _____ Date :_____

I understand that if my insurance company requires a referral or pre-authorization for my visit it is my responsibility to obtain this referral from my referring physician or primary care physician prior to my appointment. If my insurance plan has a maximum benefits or limitations on number of visits allowed, I understand it is ultimately **my responsibility** to keep track of the number of visits permitted and the number I have used and that I will be billed if the therapy visit is not covered due to this.

Legal signature of or on behalf of patient _____ Date: _____

I understand if I have an unpaid balance to Palmetto SPOT and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Palmetto SPOT or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Palmetto SPOT and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Legal signature of or on behalf of patient _____ Date: _____