NORTHLAND AUDIOLOGY & Hearing Services

*Improve Your Hearing…Improve Your Life!*

Jordan Creek Center
8800 Glacier Hwy, Ste 116
Juneau, Alaska 99801

Phone: 907.789.6780
Fax: 907.789.5828
Text: 907.465.7755

**northlandaudiology.com**
**intake@northlandaudiology.com**

# Patient Intake Form (Page 1 of 2)

Date: _____

Patient name: _____ Date of Birth: _____ Sex: ◯Female ◯Male
*(First, Middle Initial, Last)*

Preferred Name *(if different than above)*: _____

Parent(s) Name(s) *(if under age 18)*: _____

Mailing Address: _____

City, State, Zip: _____

Physical or Snowbird Address *(if different than mailing)*: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-mail Address: _____

Preferred Contact Method: ◯Home ◯Cell ◯Work ◯Email ◯Caregiver ◯Other: _____

Name of Employer: _____ Phone number: _____

Names of Physician & Clinic: _____

Referred By: ◯Self ◯Employer ◯Friend ◯Family ◯Physician ◯Other: _____

How did you learn about Northland Audiology & Hearing Services?:

☐Family/Friend ☐Physician ☐Internet ☐Social Media ☐Radio ☐Yellow Pages ☐Newspaper ☐Other

**Caregiver Contact Information:** *(If not applicable, leave the following section blank)*

Name: _____ Relationship to patient: _____

Date of Birth: _____ Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

**Person Responsible for Payment:** ◯Self *(Leave the following section blank)* ◯Other *(Please fill out this section)*

Name: _____ Relationship to patient: _____

Date of Birth: _____ Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-mail Address: _____ Name of Employer: _____

**Emergency Contact Information:** ◯Person Responsible for Payment ◯Caregiver ◯Other *(Please fill out this section)*

Name: _____ Relationship to patient: _____

Date of Birth: _____ Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

# Patient Intake Form 

**Policy**: We request at least 24-hours notice if you need to cancel your appointment. Failure to do so may result in a no-show fee.

It is advised that you consult your insurance company to determine your policy coverage, requirements and restrictions. Please be reminded that your insurance policy is a contract between *you and your insurance company.* Payment is due at the time of service. If you have insurance coverage for *medical hearing services*, a co-payment (generally 20%) will be accepted. If we receive accurate policy information we will be able to courtesy bill your insurance company in a timely manner. After all insurance policies have been responded to, we will mail you an invoice if there is balance remaining. A *$5.00 late fee* will be applied to outstanding balances each month, beginning 30 days after the first mailed invoice.

Medicare's policy requires a written referral from your physician prior to receiving a hearing evaluation by an audiologist. Medicare does not cover services related to hearing aids, ear molds, or exams to determine a need for hearing aids. If Medicare denies payment, you will be responsible for the balance due.

Medicaid/Denali Kid Care provides you with a current Medicaid card to be presented to us at the time of service. Northland Audiology will submit the appropriate claim forms on your behalf if proof of coverage is obtained.

SEARHC, KIC, DVR and VA benefits do not apply to private practice unless pre-authorized for payment.

CONSENT: I have read and understand the information regarding insurance, payment, and privacy. I give my consent for Northland Audiology to release to the named insurance carrier(s) any information necessary to expedite payment. I authorize all insurance benefits to be paid directly to Northland Audiology. I understand that I am responsible for all charges, regardless of insurance coverage. I also agree to pay all collection agency fees if this claim(s) should go to collections.

We may on occasion send you newsletters or notices of special events or offers. If you wish *not* to receive these, please initial here. _____

Signature _____ Date _____

**Primary Policy:** Patient Relationship to Insured: ◯Self ◯Spouse ◯Child ◯Other:_____

Name of Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number (Including any letters): _____Group #:_____

**Secondary Policy:** Patient Relationship to Insured: ◯Self ◯Spouse ◯Child ◯Other:_____

Name of Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number (Including any letters): _____Group #: _____

**Tertiary Policy:** Patient Relationship to Insured: ◯Self ◯Spouse ◯Child ◯Other:_____

Name of Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number (Including any letters): _____Group #: _____