ISU Audiology Clinic
650 Memorial Dr., Bldg. 68, Pocatello, ID 83209
Phone: 208.282.3495 / Fax: 208.282.4571

Pediatric Patient Demographics

Patient Name: _____ **DOB:** _____
Parent/Guardian: _____ **Sex:** ☐ Male ☐ Female
Address: _____ **Home Phone:** _____
_____ **Cell Phone:** _____
Pediatrician: _____ **Office Phone:** _____
Referred By: _____ **Primary Language:** _____
Patient is: ☐ ISU Student ☐ ISU Faculty/Staff ☐ ISU Faculty/Staff Family Member ☐ N/A
Appt. Reminder: ☐ Text [Carrier: _____] ☐ Email: _____

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Regence BS ☐ Medicare ☐ Medicaid ☐ Pacific Source
☐ Select Health ☐ VA ☐ Ameriben ☐ UHC ☐ Tricare
☐ Private Pay ☐ Student Health ☐ Other: _____

Primary Subscriber ID: _____ **Group No.:** _____
Subscriber Name: _____ **DOB:** _____
Secondary Subscriber ID: _____ **Group No.:** _____
Subscriber Name: _____ **DOB:** _____
Address: (if different from above) _____

Financial Policy

As the patient, you are responsible for all non-covered charges in our office. While we try to navigate the insurance process for you as much as possible, it is your responsibility to know your insurance benefits, and negotiate disputed claims when necessary.

If you do NOT have insurance- Our policy requires payment in full, or a down payment to be made at the time of your visit.

☐ **No Insurance-** Checking this box indicates that you have asked us not to bill insurance, and that you agree to make a payment at the time of service. Please note that there will be a fee for service unless otherwise stated.

If you DO have insurance- If you have not met your insurance deductible, you will need to make a $50 payment at the time of service and you will receive a statement after the insurance has processed your claim. Please present your insurance card to the front desk, so that they can run your insurance in a timely manner.

Medicare/ Medicaid- It is YOUR RESPONSIBILITY to make sure that you have a Physician referral before you are seen. If you do not have a referral, Medicare/Medicaid will not pay your claims and you will be responsible for any non-covered and/or unauthorized charges.

VA- Please be aware that if we do not have a referral from the VA we will not be able to see you. Even if the VA scheduled your appointment for you, we cannot see you unless they have sent a referral.

Rejected Claims- While we verify your insurance benefits before you are seen, the insurance company will not guarantee payment until after you have been seen. Sometimes insurance companies will reject claims unexpectedly. When this happens, you are responsible for any and all non-covered charges.

Payment Plans- While we do not offer payment plans, we do accept Care Credit and if you are interested, we can help you apply for a credit card.

If you have any questions, please contact the front desk at 208-282-3495.

By signing the consent below, I acknowledge that I have read and agree to the above terms.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all charges regardless of insurance and/or self-pay and understand the financial policy above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

_____ **Date:** _____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

Medications:

Are you currently taking any prescription medication? ☐ Yes ☐ No If yes, please describe below.

	Prescription Name	**Dosage Per Day**	**Purpose or Reason Taken**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Are you currently taking any over the counter medication? ☐ Yes ☐ No If yes, please list below.			
	Medication Name	**Dosage Per Day**	**Purpose or Reason Taken**
1.			
2.			
3.			
4.			
5.			

Drug Allergies:	
Do you have any drug related allergies? ☐ Yes ☐ No If yes, please list below with reaction.	
1.	
2.	
3.	
4.	
5.	

Health Problems: (Please describe any health problems.)

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Consent for Participation

I _____, give permission for the faculty and students of the Idaho State University Audiology Clinic to use information gathered from my participation of educational training. I understand that students, under the supervision of fully licensed faculty clinicians, will be observing and conducting my treatment and/or evaluation as part of the student's education. In addition, I also understand that students in the educational process will be reviewing my evaluation and treatment results and records.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the Clinic Director and the Department Chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file in the Department of Communication Sciences & Disorders.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Authorization to Obtain Emergency Medical Treatment

I authorize the Idaho State University Audiology Clinic to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney

☐ Other: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Audiology Clinic Notice of Privacy Practices.

_____
Print Name of Patient

_____ _____
Signature of Patient or Personal Representative *Date*

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date