Client Registration

(Please print clearly)

Client Name: ____ Birth Date: ___________

Last *First* *MI*

☐ Male ☐ Female Race/Ethnicity: ________________________ ☐ Decline

Primary Language: _____________________ Do you have a preference for interpreter? ☐ Yes ☐ No ☐ No preference

Address: ____

Street *City* *State* *Zip* *County*

Home Phone: ____________________________ Mobile Phone: ____________________________

Other Phone: ____________________________ My primary phone is ☐ Home ☐ Mobile

Preferred way to receive appointment notifications ☐ Text ☐ Phone ☐ Email

Email Address: ______________________________________ Are you a U.S. Veteran? ☐ Yes ☐ No

If the client is a child, name of child's parent(s) or guardian(s): ______________________________

Address if different than child: ____

How did you hear about the Center for Hearing & Speech? ______________________________

Do you live in a nursing, retirement or group home, or rehab center? ☐ Yes ☐ No

If yes, what is the name of the facility? ______________________________________

Is there a contact person we should talk to? _________________________ Phone: ________________

Do you have a guardian or power of attorney? ☐ Yes ☐ No

If yes, what is their name? ________________________________ Phone: ________________

Who is your primary physician? ______________________________ Phone: ________________

If referred here by a physician, what is their name? ____________________ Phone: ________________

Do you give permission for the Center to speak to these physicians about your services and condition? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: ____________________________ Insured's Name: ____________________

Address and phone if different from client: ______________________________________

Insurance Company Name: ____________________________ Insured's Name: ____________________

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: ____________________________ Insured's Name: ____________________

Address and phone if different from client: ______________________________________

Insurance Company Name: ____________________________ Insured's Name: ____________________

IF YOU HAVE ANY ADDITIONAL INSURANCE, PLEASE NOTIFY US.

We are responsible for organizations that contribute financially to our programs. They want to know that we are providing services to individuals at all income levels. Names are never included in our reports. Please assist us by marking your household income level below.

☐ under $19,999 ☐ $20,000–$49,999 ☐ $50,000–$74,999 ☐ $75,000–$99,999 ☐ $100,000+

Number of people living in your household: ______________________________ Are you employed? YES ☐ NO ☐

If there is an emergency while you are at the Center, who should we call?

Name: ____ Phone: ______________________________

Relationship: ____ Alt Phone: ___________________________

Other than the people you have already listed, who can we talk with about your services and condition?

Name: ____________________________ Relationship: __________________ Phone: ___________________

Name: ____________________________ Relationship: __________________ Phone: ___________________

I authorize the release of all information necessary to process claims related to care provided to me by the Center for Hearing & Speech and authorize the Center to apply for benefits on my behalf and authorize my insurance company to send payment directly to the Center. I certify that the information reported regarding insurance coverage is accurate and permit a copy of this authorization to be used in place of the original.

I authorize the Center to talk with the people listed on this form.

This release is valid until I provide a written statement revoking my authorization.

I understand that I am responsible for paying the cost for services I receive and for any charges my insurance or payer does not pay. I understand that payer sources may audit records to verify services were provided. Tardiness of more than 15 minutes or more may require you to reschedule.

____ ________________________

Signature of client or guardian Date

THANK YOU FOR CHOOSING THE CENTER FOR HEARING & SPEECH.