



**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_  
(LAST) (FIRST) (MI)

ADDRESS: \_\_\_\_\_  
(STREET) (APT#) (CITY) (STATE) (ZIP)

HOME NUMBER: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ GENDER: M F STATUS: S M D SEP W

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DRIVERS LICENSE NUMBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE #: ( ) \_\_\_\_\_

EMERGENCY CONTACT ADDRESS: \_\_\_\_\_  
(STREET) (APT#) (CITY) (STATE) (ZIP)

REFERRAL SOURCE:  Physician  Audiologist  Friend or Family Member  Insurance Company or Hospital  
 Yellow Pages  YellowPages.com  Internet/Website  Marketing  Other \_\_\_\_\_

REFERRING PHYSICIAN (IF APPLICABLE): \_\_\_\_\_ ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (STE#) (CITY) (STATE) (ZIP)

PRIMARY CARE PHYSICIAN (IF APPLICABLE): \_\_\_\_\_ ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (STE#) (CITY) (STATE) (ZIP)

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_\_

SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_\_

SUBSCRIBER'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

SUBSCRIBER'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

SUBSCRIBER'S RELATIONSHIP TO PT: \_\_\_\_\_  
(e.g., self, spouse, mother, father)

SUBSCRIBER'S RELATIONSHIP TO PT: \_\_\_\_\_  
(e.g., self, spouse, mother, father)

EMPLOYER NAME: \_\_\_\_\_  
(If patient is a minor or married, please list parent/guardian/spouse employer and address information.)

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER PHONE NUMBER: \_( ) \_\_\_\_\_

EMPLOYER PHONE NUMBER: \_( ) \_\_\_\_\_

SUBSCRIBER/POLICY #: \_\_\_\_\_

SUSCRIBER/POLICY#: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

INSURANCE CLAIM MAILING ADDRESS: \_\_\_\_\_

INSURANCE CLAIM MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
(NOT HOME ADDRESS)

\_\_\_\_\_  
(NOT HOME ADDRESS)

**PLEASE TURN OVER TO READ AND SIGN, THANK YOU.**

## FINANCIAL AND OFFICE POLICIES

### Cancellation / Missed Appointment Policy

Our office will notify you by Televox 2 days prior to your appointment. **It is your responsibility to ensure we have an up-to-date telephone number on file.**

**A 48 hour advance notice for cancellation or rescheduling of all appointments is required.** All patients who arrive more than 5 minutes late of their scheduled appointment/test or cancel their appointment with less than 48 hours notice will be charged for the missed appointment/test. This fee is not covered by Medicare or insurance plans. The charge for a missed appointment is **\$300** for a physician/physician assistant appointment and **50% of the charges** for any scheduled tests.

### Electronic Services Policy

Dr. Maw is pleased to offer patients professional services by electronic means (telephone, internet or fax) and completion of insurance, work or school forms. These services are subject to a minimum \$25.00 charge and are otherwise prorated at an hourly charge of \$400.00/hour. Dictated letters are \$200.00 per page. These charges do not apply to postoperative patients for 90 days post surgery, but otherwise are the responsibility of the patient. Our prescription call-in fee is \$25.00.

### Assignment, Release and Financial Agreement

I authorize treatment of \_\_\_\_\_ and agree to pay all fees for  
(Patient's Name)

Services and treatment provided by Dr. Jennifer Maw and/or her designated providers. I hereby authorize my insurance benefits to be paid directly to Dr. Maw for services provided, and I realize that I am financially responsible for any services not covered by my insurance company. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I understand that my insurance company may deny payment for any reason including but not limited to the following: services not authorized by primary care provider, services not authorized /covered by my insurance company. Any claims paid to Dr. Maw by the insurance after full payment by the patient will be refunded. I acknowledge that failure to meet my financial obligations may result in referral of my account to a collection agency.

I have read and understand all of the above financial and office policies.

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_