EARS
Ear Associates & Rehabilitation Services Inc.

Patient Information

Patient Name _____ Date of Birth ____ /____ /____ Age ____
First Last MI MM DD YYYY

Address _____
Street Apt # City State Zip

Home Number ( ) _____ Work ( ) _____ Cell ( ) _____

Email Address _____ Gender: Male Female Status: Single Married Divorced Separated Widowed

Social Security Number _____ Drivers License _____

Emergency Contact _____ Relation _____ Phone ( ) _____

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) _____ Phone ( ) _____

Address _____
Street Apt # City State Zip

Primary Care Physician (if applicable) _____

Address _____
Street Apt # City State Zip

Insurance Information

Primary Insurance

Insurance Name _____
Subscriber's Name _____
Subscriber's Date of Birth _____
Subscriber's SSN _____
Subscriber's Relation 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 Phone ( )_____
Subscriber's Policy # _____
Group Number _____
Insurance Claim Mailing Address _____
_____
(not home address)

Secondary Insurance

Insurance Name _____
Subscriber's Name _____
Subscriber's Date of Birth _____
Subscriber's SSN _____
Subscriber's Relation to PT _____
(e.g., self, spouse, mother, father)

Employer Name _____

Employer Phone ( )_____
Subscriber's Policy # _____
Group Number _____
Insurance Claim Mailing Address _____
_____
(not home address)

FINANCIAL AND OFFICE POLICIES

Cancellation/Missed Appointment Policy

Our office will notify you by TeleVox 3 days prior to your appointment. It is your responsibility to ensure we have an up-to-date telephone number on file.

As our audiology and medical schedules are intertwined, a 48 hour advance notice for cancellation or rescheduling of all appointments is required. We reserve the right to reschedule your appointment if you arrive more than 5 minutes late of your scheduled appointment/test. Patients who cancel without notice or miss more than 3 appointments will be charged a fee of $300. This fee is not covered by Medicare or insurance plans.

Co-payments

Our office requires that co-payments must be paid on the day of your appointment. There will be a $25 fee for any co-payment that is not paid at this time.

Returned Checks

Our office charges a $30 fee for all returned checks.

Electronic Services Policy

Dr. Maw is pleased to offer patients professional services by electronic means and completion of insurance, work or other 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 $100.00 per page. These charges do not apply to postoperative patients for 90 days post surgery, but otherwise are the responsibility of the patient.

Assignment, Release and Financial Agreement

I authorize treatment of _____ and agree to pay all fees for services and treatment provided
(Patient's Name)
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 services not authorized by my primary care provider and 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 _____