Heuser Hearing Institute
Heuser Hearing & Language Academy

INITIAL PROVIDER	ONGOING PROVIDER
PATIENT TYPE	SCHOOL SYSTEM
SERVICE PROVIDED	FREQUENCY OF SERVICE
	OFFICE USE ONLY

BILLING INFORMATION

Client's Full Name: ____ Date of Birth: ______________

Client's Address: ____

City/State: ___________________________________ County: ____________________ Zip: ____________

Home Phone: ______________________ Social Security No: _______________________________________

Work Number: ________________________ Emergency Contact Number: __________________________

Primary Care Physician: _________________________ Address: ___________________________________

Primary Care Physician Phone No.: _______________________

Referring Physician:______________________________ Address: __________________________________

Father's Name: _________________________ (If child) Mother's Name: ___________________ (If child)

Employer: ____________ Work Phone: __________ Employer: _____________ Work Phone: _________

Primary Insurance:___________________________________ Group No.:___________________

Subscriber's Name:_____________________________________ I.D. No.:_____________________

Date of Birth: _______________________

Secondary Insurance:_________________________________ Group No.: __________________

Subscriber's Name: __________________________________ I.D. No.: ____________________

Date of Birth: ________________________

Please check any of the following methods that apply to your coverage:

_____ Self Pay
_____ Insurance filed by patient
_____ Insurance filed by Heuser Hearing Institute
_____ Referred by Vocational Rehabilitation
_____ Other (Please explain) ____

_____ First Steps CBIS# ___________________
_____ Disability Determinations
___ School District

I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to The Heuser Hearing Institute. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection. I understand that as a Medicaid recipient and over the age of 21 years, I am fully responsible for my bill.

SIGNATURE ______________________________ DATE ______________________

10/1/13