### Indiana University Speech-Language & Hearing Clinics

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Hearing Clinic | | | | | | | | | | | | | | | | | | | | | | Speech-Language Clinic | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: | | | | | | | First: | | | | | | | | Middle: | | | | | | | Mr.  Mrs.  Miss  Ms.  No title | | | | Marital Status: Single  Spouse/Domestic partner  Div  Sep  Wid | | | | | | |
| Is this your legal name?  Yes  No | | | If not, what is your legal name? | | | | | | | | | | | | (Former name): | | | | | | | | Birth date: | | | | | | | Age: | | Sex:  M  F  Other |
| Street Address: | | | | | | | | | | | | | | | | | | Home Phone# :  (     ) | | | | | | | | | | Cell Phone #:  (     ) | | | | |
| City: | | | | | | | | | | | | State: | | | | | | | | Zip Code: | | | | | E-mail Address: | | | | | | | |
| Preferred Method of Communication:  Home Phone  Cell Phone  For this number, please check the appropriate box:  OK to leave a message with detailed information  Leave a message with call-back number only  Secure email | | | | | | | | | | | | | | | | | | | | Secondary Method of Communication:  Home Phone  Cell Phone  For this number, please check the appropriate box:  OK to leave a message with detailed information  Leave a message with call-back number only  Secure email | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | Employer: | | | | | | | | | | | | | | | Employer Phone #:  (     ) | | | | | |
| Referred to clinic by (Please check one box): | | | | | | | | | | | | | | | | | | | | Dr. | |  | | | | | | | Insurance plan | | | Hospital |
| Family | Friend | | | Close to home/work | | | | | | | | | | | Yellow Pages  Other | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In case of emergency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home Phone #: | Cell Phone #: | |  |  | (     ) | (     ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATIONCompleted claim Forms available as a courtesy but will not be submitted directly to insurers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | Birth Date: | | | | | | | | | Address (if different): | | | | | | | | | | | | | Home Phone #:  (     ) | | | | | |
| Is this person a patient here? | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | Employer: | | | | | | | | | Employer Address: | | | | | | | | | | | | | | | | Employer Phone #:  (     ) | | | | | |
| Is this patient covered by insurance?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance company: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Subscriber’s Name: | | | | | | Insurance ID #: | | | | | | | | | | Birth Date: | | | | | Group #: | | | | | | Policy #: | | | | | Co-payment:  $ |
| Patient’s relationship to subscriber: | | | | | | | | Self | | | | | Spouse | | | | Child | | | | Other | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | Subscriber’s Name: | | | | | | | | | Birth Date: | | | | | Group #: | | | | | | | Policy #: | |
| Patient’s relationship to subscriber: | | | | | | | | | Self | | | | Spouse | | | | Child | | | | Other | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IU Bursar information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Bill to your bursar account? (IU students only) | Yes | No | N/A | Student ID#: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CONSENT AND AUTHORIZATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | If I qualify for an upcoming research investigation, please inform me so that I may consider participating | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| My signature below confirms that I have reviewed the “Notices of Privacy Practices” and its explanation of how the IU Speech-Language & Hearing Clinics will use my personal health information in relation to treatment, payment and healthcare operations, as well as my rights regarding the management of this information.  I also authorize the IU Speech-Language & Hearing Clinics, their agents, and employees and students to provide evaluation and treatment services. I understand that the IU Speech-Language & Hearing Clinics are an educational institution and I agree that student clinicians (in training to be speech pathologists and audiologists) may provide care under the supervision of licensed speech pathologists and audiologists.  I understand that the IU Speech-Language and Hearing Clinics expect that parent(s)/guardian(s) of all minors, or otherwise incapacitated individuals, receiving treatment remain present and on premises while such minor, or otherwise incapacitated individual, is receiving treatment. Parent(s)/guardian(s) remain primarily responsible for the decision(s) regarding the treatment of their minor child, or otherwise incapacitated individual, and will consult and consent with the Clinic regarding the provision of care.  Should I be absent from the premises for any reason, I hereby authorize qualified medical professionals to transport and provide medical treatment to my child, or otherwise incapacitated person for which I am responsible, as needed and I waive my right to receive informed consent prior to any such transportation or treatment  I understand that the IU Speech-Language & Hearing Clinics may provide me with completed insurance claim forms should I choose to submit claims to an insurance carrier. I authorize communication of my health information between the IU Speech-Language & Hearing Clinics and my insurance company. I further understand that I am fully responsible for payment of services provided in this office for myself or my dependents. I understand that if I do not make payments in a timely manner for services received from the IU Speech-Language & Hearing Clinics, the Clinics may pursue collection of any past due balance through the use of an collection agency or an attorney. In the event this becomes necessary, I understand that I will be responsible for any and all finance charge(s), collection charge(s), and/or attorney fee(s) that may result.   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | **Patient/Guardian signature** |  | **Date** |   Return form to:  **IU Speech-Language & Hearing Clinics**  **2631 E Discovery Parkway**  **Bloomington, IN 47408**  **Phone: 812-855-7439**  **Fax: 866-981-1874** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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