Idaho State University

ISU Audiology Clinic
650 Memorial Dr., Bldg. 68, Pocatello, ID 83209
Phone: 208.282.3495 / Fax: 208.282.4571

Adult Patient Demographics

Patient Name: ______________________ **DOB:** ______________
Address: ______________________ **Sex:** ☐ Male ☐ Female
______________________ **Home Phone:** ______________
Work Phone: ______________________ **Cell Phone:** ______________
Physician: ______________________ **Office Phone:** ______________
Referred By: ______________________ **Primary Language:** ______________
Patient is: ☐ ISU Student ☐ ISU Faculty/Staff ☐ ISU Faculty/Staff Family Member ☐ N/A

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Regence BS ☐ Medicare ☐ Medicaid ☐ Pacific Source
☐ Select Health ☐ VA ☐ Ameriben ☐ UHC ☐ Tricare
☐ Private Pay ☐ Student Health ☐ Other: ______________________

Primary Subscriber ID: ______________________ **Group No.:** ______________
Subscriber Name: ______________________ **DOB:** ______________
Secondary Subscriber ID: ______________________ **Group No.:** ______________
Subscriber Name: ______________________ **DOB:** ______________
Address: (if different from above) ______________________
Employer: ______________________ **Student Status:** ☐ FT ☐ PT

Billing Policy

We bill all major insurance companies. We recommend a physician's referral or prescription for services. **Medicaid patients are required to have a physician's referral and possibly a Healthy Connection**. All co-pays and co-insurance will be collected at the time of service. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. At a minimum, payments must be made monthly. All fees must be paid in full by the end of the semester to be eligible for continued services. Accounts past due more than 90 days will be sent to collections and any cash discounts applied will be removed and you will be responsible for regular therapy pricing.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all charges regardless of insurance and understand the billing policy as stated above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

Signed By: ______________________ **Date:** ______________
Patient/Guardian or Responsible Party

Medications:			
Are you currently taking any prescription medication? ☐ Yes ☐ No If yes, please describe below.			
	Prescription Name	**Dosage Per Day**	**Purpose or Reason Taken**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Are you currently taking any over the counter medication? ☐ Yes ☐ No If yes, please list below.			
	Medication Name	**Dosage Per Day**	**Purpose or Reason Taken**
1.			
2.			
3.			
4.			
5.			

Drug Allergies:	
Do you have any drug related allergies? ☐ Yes ☐ No If yes, please list below with reaction.	
1.	
2.	
3.	
4.	
5.	

Health Problems: (Please describe any health problems.)