Indiana University Speech-Language & Hearing Clinics
REGISTRATION FORM

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 INFORMATION

COMPLETED 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:

 SEE OTHER SIDE

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 & 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 East Discovery Parkway
Bloomington, IN 47408

30April21