Memphis Oral School for the Deaf

Empowering Deaf Children to Listen, Learn, and Talk

Speech & Hearing Center of the Mid-South
dba Memphis Oral School for the Deaf
7901 Poplar Avenue
Germantown, TN 38138
901-758-2228 901-531-6735 fax

PATIENT INFORMATION

Patient's Name _____
(First) (Initial) (Last)

Address _____
(Street) (City) (State) (Zip)

Cell _____ Work _____ Email _____

DOB _____ Age _____ Sex _____ Marital Status _____ SSN _____

Referring Physician _____ Phone _____

Clinic/Address _____
(Street) (City) (State) (Zip)

PREFERRED / AUTHORIZED METHOD OF CONTACT

Email: ☐ Yes ☐ No Voice Mail: ☐ Yes ☐ No Text Msg: ☐ Yes ☐ No

Email _____ Phone # _____ Phone # _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____ Relationship _____ Phone _____

PATIENT INSURANCE INFORMATION

Primary Insurance _____ Member ID _____ Group _____

Insured's Name _____ DOB _____

Secondary Insurance _____ Member/ID _____ Group _____

Insured's Name _____ DOB _____

RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

Name _____
(First) (Initial) (Last)

Address _____
(Street) (City) (State) (Zip)

Cell _____ Work _____ Email _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received and reviewed a copy of the Notice of Privacy Practices for Speech & Hearing Center of the Mid-South, dba Memphis Oral School for the Deaf.

_____ _____ _____
Patient Name (print) Patient / Guardian Signature Date

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION & CONSENT

I authorize Speech & Hearing Center of the Mid-South, dba Memphis Oral School for the Deaf, to provide evaluations and/or treatment, release patient's information to the insurance company, and I authorize the direct payment of any medical benefits from the insurance company for services rendered. I understand and agree that charges not covered by my insurance company, as well as co-payments, co-insurance and deductibles are my responsibility.

For Self-Pay, a standardized payment formula will be used for evaluations, diagnostic procedures, office visits and other services received.

_____ _____ _____
Patient Name (print) **Patient / Guardian Signature** **Date**