Atos Medical
Your voice

Patient Services Form

*Required

PATIENT INFORMATION

FIRST NAME*	MI	LAST NAME*	GENDER ❍ Male ❍ Female
STREET*			MEDICARE? ❍ Yes ❍ No
CITY*	STATE*	ZIP*	LANGUAGE (IF NOT ENGLISH) ❍ Spanish ❍ Other _____
DATE OF BIRTH (MM/DD/YYYY)*	EMAIL		CURRENT VOICING METHODS ❍ Provox Voice Prosthesis ❍ Other Voice Prosthesis ❍ Esophageal Speech ❍ Hands-Free Device ❍ Electrolarynx ❍ Other _____
TELEPHONE*	MOBILE TELEPHONE		
PRIMARY CARE PHYSICIAN NAME	PHYSICIAN TELEPHONE	PHYSICIAN FAX	
CLINICIAN NAME	CLINICIAN TELEPHONE	CLINICIAN FAX	
DATE OF SURGERY (MM/DD/YYYY)	DATE OF PUNCTURE (MM/DD/YYYY)		BEST TIME TO CONTACT? ❍ 8am-11am ❍ 11am-1pm ❍ 1pm-4pm ❍ 4pm-7pm

AUTHORIZED REPRESENTATIVE/CAREGIVER DESIGNATION

IMPORTANT: Atos is not allowed to communicate with anyone on your behalf without authorization. If you do not wish to designate a representative, please add N/A to the required fields.

I designate the below listed Authorized Representative(s) whom I have chosen to assist with the handling of my account with Atos Medical Inc (Atos) on my behalf. I authorize Atos to exchange my protected health information with the following individual(s). I understand that I may update or revoke my Authorized Representative list at any time by submitting a written request.

AUTHORIZED REP/CAREGIVER 1 (FIRST/LAST)*	RELATIONSHIP TO PATIENT	TELEPHONE*	EMAIL*
AUTHORIZED REP/CAREGIVER 2 (FIRST/LAST)	RELATIONSHIP TO PATIENT	TELEPHONE	EMAIL
THIS REQUEST AND AUTHORIZATION APPLIES TO ALL INFORMATION RELATED TO MY ACCOUNT UNLESS SPECIFIED:			

INSURANCE INFORMATION

Please mail or fax copies of the front and back of your insurance card(s) to Atos Medical Inc., attention Patient Services. If you do not have insurance, please add N/A to the required fields.

PRIMARY INSURANCE COMPANY NAME*	POLICY#*	GROUP#*	TELEPHONE
POLICYHOLDER NAME*	DATE OF BIRTH (MM/DD/YYYY)	PATIENT RELATIONSHIP TO INSURED	
SECONDARY INSURANCE COMPANY NAME	POLICY#	GROUP#	TELEPHONE
POLICYHOLDER NAME	DATE OF BIRTH (MM/DD/YYYY)	PATIENT RELATIONSHIP TO INSURED	

CONSENT STATEMENT

IMPORTANT: Box must be checked to receive any communication via email or telephone.

Check ☐ By checking this box and signing this form, you are agreeing to receive telephone, written and electronic communications from Atos via the telephone number, mailing address, email address and/or electronic application profile information you have provided, including information regarding your products and orders. For marketing purposes, you are also requesting to receive promotions, product updates and company information from Atos. Please notify us if you do not wish to receive such communications and we will not use or disclose your information for these purposes.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Patient Services Book which contains Patient Bill of Rights and Responsibilities, Patient Service Agreement, Notice of Privacy Practices (HIPAA), Ordering Laryngectomy Supplies and Understanding Your Insurance Benefits. I understand the information and agree to the terms. If a Healthcare Power of Attorney (HCPOA) is in place, the Agent can sign instead of the Patient.

PATIENT SIGNATURE*	DATE*
HCPOA AGENT SIGNATURE (IF APPLICABLE)	DATE

For Internal Use Only	ACCT#

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Print Form and Sign