HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ______
Address: ____
City, State and Zip: ____
Home Phone: ______________________ Date of Birth: ______________________
Cell Phone: ______________________ Work Phone: ______________________
Email Address: ____
Emergency Contact: ______________________ Phone: ______________________
Employment Status: Full Time [ ] Part Time [ ] Student [ ] Retired [ ] Sex: Male [ ] Female [ ]
Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Referring Physician: ______________________ Primary Physician: ______________________

Insurance Information

Primary Insurance:

Plan Name: ______________________ Policy/ID# ______________________ Group#: ______________
Subscriber's Name: ______________________ Patient Relationship to Subscriber: ______________
Subscriber's DOB: ______________________ Subscriber's Employer: ______________________

Secondary Insurance:

Plan Name: ______________________ Policy/ID# ______________________ Group#: ______________
Subscriber's Name: ______________________ Patient Relationship to Subscriber: ______________
Subscriber's DOB: ______________________ Subscriber's Employer: ______________________

Guarantor Information – *Person responsible for payment for services rendered by Hearing Professionals.*

Guarantor Name: ____
Address: ______________________ Phone: ______________________
City, State and Zip: ____

Patient's Authorization

I authorize HEARING PROFESSIONALS, INC. to apply for benefits on my behalf for services rendered by HEARING PROFESSIONALS, INC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize HEARING PROFESSIONALS, INC. to collect any payment made by insurance carrier for services rendered and billed by HEARING PROFESSIONALS, INC. I permit a copy this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. **I also agree to abide by HEARING PROFESSIONALS, INC. 24 hour cancellation policy and understand that I may be charged between $35 and $100 if proper notification is not given.**

______________________________ ______________________________
Signature of Patient or Guardian Date

Updated 11/2011