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