



HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Pediatric Patient Information

Patient Information

Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City, State and Zip: _____
 Patient's Date of Birth: _____ Mother's Name: _____
 Home Phone: _____ Mother's Date of Birth: _____

Parent/Guarantor Information *(Guarantor is the person responsible for payment for services rendered by Hearing Professionals.)*

Last Name: _____ First Name: _____ MI: _____
 Address (If different than patient): _____
 Date of Birth: _____ Cell Phone: _____
 Home Phone: _____ Work Phone: _____
 Email Address: _____

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: _____

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 Parent or Guardian

Date