Cadence Hearing Services, LLC

Name_____ Date of Birth_____

Street Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Cell Phone Number_____

How did you Hear about us?_____

Parent/GuardiansName_____

Parent/GuardiansName_____

Address if different from above_____

Phone Number if different from above_____

Type of Insurance_____ Policy Number_____

Name and Date of Birth of Policy Holder_____

Name of Primary Physician_____ Address_____

City_____ State_____ Zip_____ Phone_____

Childs Current school_____ Address_____

Phone Number_____ Current Grade_____

I understand that I am financially responsible for payment of services rendered by Cadence Hearing Services, LLC. I request that payment for authorized insurance benefits and or Medicare Benefits be made to me or on my behalf to this doctor. I authorize any holder of medical information to release it the appropriate agents any information needed to determine these benefits payable for related services. A copy of my signature is as good as the original. My practice is committed to securing the privacy of your health information. You are not required to read the practice's notice of Privacy Practice, but it is available to you. However, we would like your acknowledgement that you have been notified that the practice has such a Privacy Practice Notice.

Signature_____ Date_____