Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: ____Zip:_____

Email: _____

Name of Insured, if different than Patient: _____

Address (if different than above)_____

Primary Insurance Plan: _____ ID#: _____ Group #:_____

Secondary Insurance Plan: _____ ID#: _____ Group #: _____

Physician: _____

Address:_____

Telephone: _____ Fax: _____

Additional Place to Send Report:

Name:_____

Address:_____

Telephone: _____ Fax: _____

I hereby agree to allow Aberdeen Audiology to share any pertainent audiological tests results with the noted professionals.

Signed: _____ Date: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Patient's or Authorized Person's Signature: I authorize payment of medical benefits to Aberdeen Audiology & Hearing Aid Center, LLC for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____