

Cadence Hearing Services, LLC

Name _____ Date of Birth _____

Address _____

Phone number _____ Cell phone _____

Email _____ How did you hear about us? _____

Insurance Information

Primary Company _____ Secondary (if applicable) Company _____

Subscriber number _____ Subscriber number _____

Policy # _____ Policy # _____

Group # _____ Group # _____

DOB _____ DOB _____

Emergency Contact _____ Phone _____

Relationship _____

Name of Primary Physician _____ Address _____

City _____ State _____ Zip _____ Phone _____

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 to 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. Within the guidelines of HIPPA, patients will be sent post cards for follow up and reminders. Please contact the office if you have any questions about our policies.

Signature _____ Date _____