

Cadence Hearing Services, LLC
207 Corporate Drive East
Langhorne PA 19047
(215) 860-3154

Name _____ Date of Birth _____

Address _____

Email _____

Phone number _____ Cell Phone _____

How did you hear about us? _____

Mother's name _____ Address _____ Phone _____

Father's name _____ Address _____ Phone _____

Type of insurance _____ Policy number _____

Date of birth of insurance card holder _____

Name of Primary Physician _____ Address _____

City _____ State _____ Zip _____ Phone _____

Child's 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 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.

Signature _____ Date _____