Angela Underhill AUDIOLOGY

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Virginia Beach, VA 23454

Please Print Clearly

LEGAL NAME_____DATE_____

LAST FIRST M.I.

ADDRESS_____

STREET CITY /STATE/ZIP

HOME PHONE_____CELL PHONE_____

EMAIL (OPTIONAL)

_____

DATE OF BIRTH_____AGE_____SEX_____MARITAL STATUS_____

OCCUPATION_____

CONTACT PERSON_____RELATIONSHIP_____

CONTACT'S PHONE NUMBER(S)

_____

REFERRAL SOURCE_____

_____

PRIMARY CARE
PHYSICIAN_____

I GIVE PERMISSION TO SEND AUDIOLOGY REPORT TO ABOVEA PHYSICIAN, EFFECTIVE FOR 1 YEAR UNLESS OTHERWISE NOTED.
INITIAL_____

INSURANCE INFORMATION

PRIMARY INSURANCE
CARRIER_____

SECONDARY INSURANCE CARRIER(S)

_____

*PLEASE PERSENT ALL INSURANCE CARDS. A PHOTOCOPY WILL BE MADE FOR YOUR CONVENIENCE.

I UNDERSTAND AND ACKNOWLEGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES RENDERED TO ME. IF INSURANCE AHS BEEN FILED ON MY BEHALF, I AGREE TO PAY ANY DEDUCTIBLE, CO-SHARE OR DENIED AMOUNT WITHIN 30 DAYS OF NOTIFICATION. I AGREE TO PAY ALL COLLECTION AND ATTORNEY FEES (25-40% OF THE BALANCE) TO BE ADDED ONTO ANY BALANCE DUE THAT IS NOT PAID AS AGREED.

SIGNED_____DATE_____

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