Cadence Hearing Services, LLC

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Marital Status_____ Phone number_____

Cell phone _____ Email _____

How did you hear about us? _____

Insurance Information

Primary	Secondary (if applicable)
Company_____	Company_____
Subscriber number_____	Subscriber number_____
DOB/name(policy holder)_____	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_____