AUDIOLOGY SERVICES OF CHATTANOOGA, INC.

"We're here to help you hear"

Patient Information Date:_____

Last_____First_____Middle_____DOB_____

Address_____City/State/Zip_____

Patient Sex__SS#_____-___-_____Name of Spouse_____Spouse DOB_____

Home Phone#_____Cell#_____Work#_____

Patient Employer_____Family Physician_____

If Minor, Name of Legal Guardian_____

Emergency Contact_____Phone#_____

Email Address_____

Referred to Our Office By_____

ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT. APPLICABLE INSURANCE WILL BE BILLED ON YOUR BEHALF.

All of the above information is strictly confidential, and will be released as required.

Date___-___-_____ Signature_____

MEDICARE EXTENDED PAYMENT REQUEST

I request that payment of authorized Medicare benefits be made to Audiology services on my behalf for any services furnished to me by the said provider. I authorize any holder of medical information about me to release to the Health Financial administration and its agents any information needed to determine benefits or the benefits payable for related services.

Date_____-_____-_____ Signature_____