The Hearing Care Clinic

Nancy A. Congdon, Au.D.
Doctor of Audiology

File No _____

Date _____

Patient Information

Name_____ Soc. Sec. # _____
(last) (first) (M.I.)

Address _____
(Street) (City) (State) (Zip Code)

Phone _____/_____ email address_____
(Home) (Work) (Ext)

Date of Birth _____ Sex: M____ F _____ Status: Single ___ Married____ Other____

Primary Physician _____Who referred you to our office? _____

Primary Insurance Information

Insurance Company _____

Subscriber ID or Policy # _____ Group # _____

Insured Name _____ Relation to Patient _____

Phone_____ Date of Birth _____ Soc Sec # _____

Address (*if different from above*) _____
(Street) (City) (State) (Zip Code)

Employer Name_____ Work Phone _____

Business Address _____

Secondary Insurance Information

Insurance Company _____

Insured Name _____Date of Birth_____ Relation to Patient _____

Subscriber ID or Policy # _____ Group # _____

Assignment of Benefits and Financial Responsibility

I authorize the release of any information necessary to process this claim. I understand that there is a fee charged for hearing tests, evaluations and other clinical services rendered at The Hearing Care Clinic. I hereby authorize payment directly to The Hearing Care Clinic of all insurance benefits, government or otherwise, payable for the services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance, for all services rendered on my behalf or my dependents and that it is my own responsibility to educate myself about my insurance benefits and limitations. I hereby agree to the following terms and conditions: There is a 1.5% monthly late charge assessed on all balances after 60 days past due. Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee. Also the undersigned agrees to pay a collection fee of 33% of the total owed when sent to collection, all attorney fees and court costs incurred by the creditor. All the information provided is correct. I give Dr. Nancy A. Congdon permission to evaluate/treat my concerns. Please send me follow up reminders, general hearing information and other mailings that may be deemed relevant to me.

I have read and understand the above paragraph in its entirety.

Signed _____ Date _____