CHILD/PARENT INFORMATION SHEET

CHILD'S NAME:_____________________________________ DATE:___________________

MAILING ADDRESS:____

____

HOME PHONE:_____________________________ CELL PHONE:______________________

DATE OF BIRTH:____________________PARENT/GUARDIAN:__________________________

E-MAIL ADDRESS:____

PRIMARY CARE DOCTOR:____

HISTORY OF MAJOR ILLNESS OR ALLERGY:____

____

Specifically: _____Diabetes _____Heart Disease _____ Stroke_____ History of Bleeding _____ Other_______________

If a **Medical Physician** must provide a written referral for your appointment today and the referral is not received by Audiology Specialists, LLC by the time of the appointment, you may be responsible for the full expense of the services provided.

I also agree to pay any charges if my Insurance Carrier denies coverage.

I also agree to pay a **$50.00** fee for any appointment I miss and fail to cancel within 24 hours of that appointment.

I understand this Policy and agree to pay any charges that I have incurred.

I request that payment of authorized Insurance Carrier benefits be made on my behalf to Audiology Specialists, LLC for any services furnished to me. I authorize the holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its Agents any information needed to determine these benefits or the benefits payable for related services. By signing below, you authorize the release of any information required by your Insurance Carrier for payment of benefits.

____ ___________________________________

Parent/Guardian Signature **Print Name**