Parker & Castle Rock Centers for

AUDIOLOGY

"Your Convenient Source for Hearing Care Services"

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY, PER YOUR CONTRACTUAL AGREEMENT WITH YOUR INSURANCE COMPANY, IN ORDER FOR US TO BILL CORRECTLY. *WE BILL YOUR INSURANCE AS A COURTESY TO YOU*. If not completed you may be considered a Self Pay patient due to lack of information to bill claims to your insurance company properly.

INSURANCE INFORMATION

PLEASE HAVE INSURANCE CARDS READY FOR US TO COPY

PRIMARY INSURANCE_____ INSURANCE HOLDER _____

GROUP NUMBER _____ DOB of INS HOLDER _____/_____/_____
MM DD YEAR

I.D. NUMBER _____ SS# of INS HOLDER_____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

SECOND/SUPPLEMENT INS._____ INSURANCE HOLDER _____
Please Circle One

GROUP NUMBER _____ DOB of INS HOLDER _____/_____/_____
MM DD YEAR

I.D. NUMBER _____ SS# of INS HOLDER_____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

MEDICARE INFORMATION

ARE YOU COVERED BY MEDICARE? YES____ NO____

IS MEDICARE PRIMARY?_____ SECONDARY?_____ or MEDICARE REPLACEMENT PLAN?_____

ASSIGNMENT OF BENEFITS (AUTHORIZATION TO PAY AND RELEASE)

I hereby authorize all benefits to be paid to **Parker Center for Audiology** for charges for examination and/or treatment received by me or my dependents. I hereby authorize benefit payers to release any and all information requested regarding such benefit payments to Parker Center For Audiology. I authorize the release of any medical information necessary to process any claim for examination and/or treatment received by me or my dependents. Verification of insurance coverage obtained over the phone **does not** guarantee payment. I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE