Stephanie Long, Au.D., Inc. About Better Care Audiology
W3124 Van Roy Road | Appleton, WI | 54915 | (920) 915-9077

Patient: _____ Male/Female DOB: ___/___/_____

Insured Person: _____ Insured DOB: ___/___/_____

Relationship to patient: _____ Phone #: _____

Address:_____

_____

_____

Insurance Information – primary (found on insurance card):

Insurance Company Name: _____

ID # or Medical Assistance #: _____ Group #: _____

Employer (of Insured): _____

Insurance Information – secondary *(if applicable)*

Insurance Company Name: _____

ID # or Medical Assistance #: _____ Group #: _____

Employer (of Insured): _____

I authorize the release of any medical or other information necessary to process claims. I also request payment of government and insurance benefits to myself or to the party (supplier) who accepts assignments of service.

I understand that if services rendered today are not covered by my insurance policy, that I am responsible for payment. I also understand that it is my responsibility, not the responsibility of the provider, to know the benefits provided by and limitations of my health insurance policy. *This authorization will be effective for one year from the date of signature.*

_____ _____

Date Patient/Parent/Legal Guardian