

Stephanie Long, Au.D., Inc. About Better Care Audiology
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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