416 4th Avenue.Suite 100
Tarentum, PA 15084

Date: ___________________________

Name: ____

Address:____

City ____State_________________ZIP___________

Home Phone: _______________________________ Other Phone: _____________________________________

Sex: ___M___F   Birth Date: ___________________________________

Email Address: ____

Primary Care Physician: _______________________________________ Clinic: ___________________________

How did you hear of our Tinnitus Clinic? :____

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TO OUR PATIENTS: OUR FINANCIAL POLICY

Please understand that payment of your bill is considered part of your service. The following is a statement of our Financial Policy, which we require you to read and sign prior to any services.

Total testing fees, initial counseling /directive counseling and program fees are payable at time of service.

Tinnitus Retraining Instruments, Hearing Aids, Musicians Plugs Hearing Protection, and the fitting, programming and educating on use of existing instrumentation are payable upon time of fitting.

We require 48 hours cancellation and reserve the right to charge a $150.00 fee for a late or missed appointment.

I have read the Financial Policy: ____Date: __________________

(Signature of Patient or Responsible Party/Date)