

Dominick Servedio Au.D.  
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Date: \_\_\_\_\_ Birthdate \_\_\_\_\_ AGE \_\_\_\_\_ SEX M F

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Marital Status S M D W

Referred by \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Send Report To \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I request that the payment of authorized Medicare or other Insurance company benefits be made either to me or on my behalf to Dominick Servedio, Au.D. for any services furnished me by the audiologist. I authorize my holder of medical information about me to release to Dominick Servedio, Au.D. any information needed to determine these benefits or the benefits Payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. This includes the release of hospital information/ if item 9 of the DCFA-1500 Claim form is completed: my signature authorizes the release of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the audiologist or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge and the patient is responsible only for the deductible, co-insurance, and charges for non covered services/ Co-insurance and the deductible are based upon the charge determination of the Medicare or other insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_