CODY AUDIOLOGY CLINIC
Dr. Brandi R. Shepard

902 Blackburn St • Cody, WY 82414 • P 307-578-2976 • www.codyhears.com

Patient Information

Patient Name: _____ Date: _____
(Last) (First)

Mailing Address: _____ Apt / Suite: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____

Marital Status: **Married** ☐ **Single** ☐ **Widowed** ☐ Spouse's Name: _____

DOB: ____ / ____ / ____ Age: _____ Gender: **Male** ☐ **Female** ☐

SS#: ____ - ____ - ____ Primary Care Physician: _____

How did you hear about us?

Referred by Physician: _____ Website: Newspaper: Facebook:

Referred by Family / Friend: _____ Mail: Other: _____

Cody Audiology Clinic Financial Policy

Thank you for choosing Cody Audiology Clinic as your hearing healthcare provider. It is our policy that payment is due at the time that equipment and service(s) are rendered.

We do participate in Medicare and some VA insurances. We will gladly bill Medicare or the VA for you after your diagnostic hearing evaluation is performed provided we have a referral from your Family Physician and authorization from the VA to do so. Unfortunately, Medicare and the VA does not cover everything for all audiological appointments. You are financially responsible for any equipment or services that are not covered.

If you have an out-of-network benefit you are responsible for payment of services and equipment due at the time of service(s) rendered. In order to help with costs, we may provide a discount at the time of your visit and an invoice of services or equipment that you can submit to your insurance. We do not bill out-of-network insurances.

I have read all the information on this form and certify this information is true and correct to the best of my knowledge. I agree to accept financial responsibility for equipment and services rendered and to accept the terms of the agreement listed above.

I, _____ agree and understand that my electronic signature is the legal equivalent of my handwritten signature.

Signature _____ Date _____

Signature _____ Date _____

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR