Audiology Partners, LLC

851 Route 73 North, Suite B, Marlton, NJ 08053 856-985-7770
Tax ID#52-2353944

___ Computer
___ Billing Date
___ Report
___ Scanned

Appt Date: _____ Provider: Rbrenner Gangelelli

Patient Information

Patient: _____ Date of Birth: _____
Address: _____
City, State,Zip _____ Sex: M F
Home Phone: Office:
Cell Phone: email address:

Insurance Information

Primary		Secondary	
Policy Holder:		Policy Holder:	
Policy #:		Policy #:	
Sex:	M F Birthdate	Sex:	M F Birthdate:
Relation:	Self Spouse Child Other	Relation:	Self Spouse Child Other

Family Doctor: _____
Address: _____ Referred By: _____
Phone: _____

Diagnosis Code/s

Gcode			
	#130 Med	#226 Tob	#261 Diz

Services

Office Visit	New	Estab
Level 1	99201___	99211___
Level 2	99202___	99212___

Hearing Aid (Service Codes Non-Medicaid)			Amount
Monaural CIC	V5254	#_____	$_____
Monaural ITC	V5255	#_____	$_____
Monaural ITE	V5256	#_____	$_____
Monaural BTE	V5257	#_____	$_____
Binaural CIC	V5258	#_____	$_____
Binaural ITC	V5259	#_____	$_____
Binaural ITE	V5260	#_____	$_____
Binaural BTE	V5261	#_____	$_____
Batteries	V5266	_____	$_____

Audio		
Comprehensive Audio		92557 _____
Tymp/Reflex		92550 _____
Tympanogram		92567 _____
Acoustic Reflex Testing		92568 _____
OAE pass/fail		92558 _____
HAE Mon		92590 _____
HAE Bin		92591 _____
HAC/adjustment Mon		92592 _____
HAC/adjustment, Bin		92593 _____
Conditioned Play		92582 _____
Visual Reinforce/Audio		92579 _____
Stenger Speech		92577 _____
Speech/Aud Threshold		92555 _____
Tinnitus Exam		92625 _____
Select Picture Audiometry		92583 _____
Eval Central Aud		***92620*** _____
Eval each add'l 15 min	Units _____	***92621*** _____
Speech/Hearing Therapy		***92507*** _____

Estimate Charge: _____
Payment _____
Method Check Cash Credit

revised 4/12/2019

I authorize release of information necessary to file a claim with my insurance carrier and request payment of benefit either to myself or to Audiology Partners, LLC if the fee has not been paid. I understand that I am financially responsible for any balance not covered by my insurance carrier. **Medicare only:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Audiology Partners, LLC for any services furnished to me by that audiologist. I authorize any holder of medical information or any information needed to determine benefits of the benefits payable for related services for me to be released to the Healthcare Financing Administration or its agents. I also understand the Medicare does not cover the cost or related cost of a hearing device.

Patient's
Signature_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OFAUDIOLOGY PARTNERS, LLC
NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE READ/RECEIVED A COPY OF AUDIOLOGY PARTNERS, LLC'S NOTICE OF PRIVACY PRACTICES.

Personal or Representatives Signature: _____

Print Patient Name: _____ Date: _____

Print Name of Personal Representative, if applicable: _____

AUDIOLOGY PARTNERS, LLC USE ONLY

If signed acknowledgment not received, document good faith efforts used to obtain:

_____

_____

REVISED 1.1.2019