

Dr. David Mendlik
Mendlik Audiology
129 E. Grant Street
West Point, NE 68788



Dr. David Mendlik
Mendlik Audiology
1627 East Military Ave
Fremont, NE 68025

MENDLIK AUDIOLOGY

Name of Patient: _____ Date of Birth: _____
Home Address: _____
City: _____ St: _____ Zip: _____
eMail address: _____
Please circle Home/Cell Phone: _____
Name of Emergency Contact with Phone: _____
Primary Care Physician: _____
Referring Doctor: _____
Place of Employment: _____

If not responsible for payment, please provide the following:

Name of Paying Adult: _____ Date of Birth: _____
Home Address: _____
City: _____ St: _____ Zip: _____
eMail address: _____ Phone: _____

Insurance Information: Please make a check next to the insurance coverage that applies:

1. Blue Cross/Blue Shield (including Medicare Supplement)
2. Champus (Military)
3. Group Insurance (through employment)*
4. Medically Handicapped Children's Program*
5. Medicaid (Department of Social Services)*
6. Medicare*
7. No Insurance/Self Pay
8. Private Insurance through an Agent (including Medicare Supplemental)*
9. Veterans Administration
10. Worker's Compensation or Personal Injury*

If there is an asterix (*) by your choice, please provide the following:

Name of Employer (if applicable): _____
Name of Insurance Company (if applicable): _____
Group Number: _____ Policy Number: _____
Name of Insurance Contact (if applicable): _____
Name of Agent (if applicable): _____

Services are rendered on a cash basis only unless previous credit arrangements have been made. The about information is warranted to be true. I agree to pay all bills upon receipt of the statement or as otherwise expressly agreed.

I authorize Mendlik Audiology to release to the Medicare carriers or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim to be made directly to Mendlik Audiology.

I understand that I am financially responsible for all charges insured.

Signature of paying adult: _____