

PROFESSIONAL HEARING SERVICES
THE DIZZINESS AND BALANCE CENTER

6231 Leesburg Pike, Suite 512, Falls Church, VA 22044 (703) 536-1666
150 Elden Street, Suite 235, Herndon, VA 20170 (703) 707-0002
8644 Sudley Road, Suite 114, Manassas, VA 20110 (703) 330-6636
8314-C Traford Lane, Springfield, VA 22153 (703) 569-0355

Patient: _____ Date: _____ Insurance Co.: _____

Thank you for choosing us as your hearing health care provider. We are committed to conscientious as well as comprehensive health care. The following is a summary of our payment policies. We ask that you **read the entire notice carefully** and acknowledge that you agree to receive these services by signing this document prior to any treatment. We will gladly answer any questions you may have.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS YOU ARE COVERED UNDER ONE OF THE INSURANCE CARRIERS WITH WHICH WE PARTICIPATE. We accept payment of cash, checks, and Visa/Master Card/Discover. Deductibles and insurance co-payments are due at the time of service.

As a courtesy, Professional Hearing Services/Dizziness and Balance Center will submit the charges for your services to your insurance carrier on a one-time basis. You are responsible for any outstanding or unpaid balance not covered by your insurance carrier.

<u>Services to be provided:</u>	<u>Procedure Code (CPT)</u>	<u>Service Fees</u>
<input type="checkbox"/> Auditory Brainstem Response (ABR)	92585	\$ 395.00
<input type="checkbox"/> Electrocochleography (ECOG)	92584	\$ 385.00
<input type="checkbox"/> Otoacoustic Emissions (OAE)	92587, 92588	\$ 90.00 – \$125.00
<input type="checkbox"/> Electronystagmography (ENG/VNG)	92542, 92543, 92544, 92545, 92547	\$ 570.00 - \$ 770.00
<input type="checkbox"/> Electro-oculography	92270	\$ 125
<input type="checkbox"/> Vestibular Evoked Myogenic Potential (VEMP)	92585, 92700	\$ 385.00
<input type="checkbox"/> Central Auditory Testing:	92620	\$ 150.00

Please choose **ONE** option below:

YES. I want to receive these services. I understand that Professional Hearing Services may bill me for the provided services that are not covered by my insurance carrier, and that I am fully responsible for all unpaid charges.

NO. I choose not to receive these services at this time.

Signature (patient or responsible person)

Date (revised 6/1/11 KT)