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Health Insurance
Signature on File

By signing this form, you are authorizing Hearing & Tinnitus Management to complete any necessary insurance Claim forms on your behalf. You are hereby also authorizing the release of any medical or other information which may be necessary in order to process your claim. Your signature will be kept on file and shall be referred to when insurance Claim forms are submitted for healthcare services you have received.

Name of Patient (Print) _____

Signature _____ Date _____