EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

PATIENT WAIVER

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.

SERVICES TO BE PROVIDED	PROCEDURE CODE (CPT)	FEE
☐ Hearing Examination	(92557, 92550)	$93.00–175.00
☐ Otoacoustic Emissions	(92587,92588)	$90–125.00
☐ Automated Auditory Brainstem Response	(92586)	$200
☐ Auditory Brainstem Response	(92585)	$395
☐ Electronystagmography ENG/VNG	(92540, 92538, 92537, 92547)	$445–770
☐ Electrocochleography	(92584)	$385
☐ Vestibular Evoked Myogenic Potential	(92585)	$385
☐ Cochlear Hydrops Analysis Masking Procedure	(92585)	$395
☐ Infrared Pressure Test	(92700, 92541, 92547)	$300
☐ Infrared Tullio Test	(92700, 92541, 92547)	$310
☐ Canalith Repositioning	(95992, 92541, 92547)	$276
☐ Central Auditory Testing	(92620)	$150–200

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 _____