

University Ear, Nose & Throat Specialists
Division of Audiology
222 Piedmont Avenue, Suite 5200
(513) 475-8453

Dear Patient,

This is to inform you prior to receiving the service listed below that your insurance company may not allow or pay for this services:

Procedure: Rotary Chair Testing

Cost of Procedure: \$510.00

Patient Consent:

University Ear, Nose and Throat Specialists have notified me that my insurance company may deny payment for the services identified above, because my insurance does not allow payment of these services. Knowing this, I request that this service be performed. If my insurance company denies payment, I agree to be personally and fully responsible for the payment.

Patient Signature: _____ Date: _____

For office use only:

Patient Signature: _____ Date: _____