DuPage Pediatrics, Ltd.

Hearing Screen Authorization

Patient's Name _____

Patient's Date of Birth_____

Your child is due for the following test/procedure (see below). Your insurance may or may not pay for these services. Insurance plans do not pay for everything, even some services that you or your health care provider have good reason to believe you need.

Test / Procedure	Insurance	Estimated Cost
EVOKE OTOACOUSTIC EMISSIONS	This test may not be covered under your plan.	$65

What you need to do:

- Read this notice so you are able to make a decision about your child's care.
- Ask us any questions that you may have after reading.
- Select an option below to choose whether or not to receive the service listed above.

Options: Check only one box. We cannot choose a box for you.
☐ OPTION 1 – I want the service listed above and authorize DuPage Pediatrics, Ltd. to bill my insurance company. I understand that if my insurance doesn't pay, I am responsible for payment.
☐ OPTION 2 – I want the service listed above. I will take responsibility for payment and do not want DuPage Pediatrics, Ltd. to bill my insurance company.
☐ OPTION 3 – I DO NOT want the service listed above.

Signing below means that you have received and understand this notice. You may also receive a copy at your request.

Signature:	Date: