SOUTHERN CONNECTICUT STATE UNIVERSITY
Department of Communication Disorders

Southern Connecticut Audiological Services

Client: _____ D.O.B: ____/_____/_____
Address: _____
City: _____State:_____Zip Code: _____
Telephone: (_____)_____e-mail: _____

Person or Agency Responsible for Payment: _____
Address: _____
City: _____State:_____Zip Code: _____
Telephone: (_____)_____e-mail: _____

Appointment Date: ____/_____/_____ **Appointment Duration** (minutes): _____

Clinician(s): _____ Instructor: _____

FOR PROFESSIONAL SERVICES:

( ) Audiological Evaluation……. N/C

( ) Hearing aid Fitting……...…... $100**

( ) Hearing Aid Order… Quantity ( ) Unit Cost $_____ Total Cost _____

( ) Hearing Aid Orientation…… N/C

( ) Earmold ……Quantity ( ) Unit Cost $_____ Total Cost $_____

( ) Hearing Aid Repair _____ $_____

( ) Hearing Aid Adjustment/Reprogramming_____ $_____

( ) Batteries…….Quantity ( ) Unit Cost $_____ Total Cost $_____

( ) Other_____ $_____

PREVIOUS BALANCE $_____

TOTAL DUE $_____

AMOUNT PAID $_____

BALANCE DUE $_____

PAYMENT METHOD: Visa MC Discover Cash Check Fee Waiver

Please make checks payable to **Southern Connecticut State University**

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