



Physician's Hearing Service

116 S. Palisade Dr., Suite 206 ▪ Santa Maria, CA 93454
Tel (805) 347-9152 ▪ Fax (805) 614-9260

Date: _____ **Phone #:** _____

User name: _____ **DOB:** _____

Hearing Aid Description: Right Left **Style:** BTE ITE ITC CIC

Description of problem:

- Not functioning: Dead Weak Intermittent
- Broken/Damaged: Battery door Wax system Hearing aid shell/case
- Need: Hearing aid cleaning Tubing change Volume adjustment (please schedule an appointment)

Other problems: _____

I authorize Physician's Hearing Service to attempt to service the hearing aid(s) for the problem(s) described above. All attempts will be made by Physician's Hearing Service to service the device(s) as soon as possible. However, under normal office circumstances, it may require 2 business days to complete this process. If a manufacture repair is required, I will be contacted for prior approval. I understand that many problems related to hearing aid malfunctions are best corrected while the individual who wears the hearing aid(s) is in the office during a scheduled appointment and a future appointment may be required to complete the requested service. Physician's Hearing Service is not liable for any manufacture repairs required as a result of attempting to repair the above hearing aid(s).

Patient /Guardian

Appointment