Provider Cancellation Form

Patient Name:_____

Address:_____

Phone Number:_____ Sycle.net #_____

Office Location:_____

Consultant Name:_____

Contract Date:_____ Amount:_____

Brief Description For Cancellation:

_____

_____

_____

_____

_____

_____

Consultant Signature:_____ Date:_____

Franchisee:_____ Date:_____

*Internal Use Only:*_____

*Signature Of Approval:*_____ *Date:*_____

Customer Refund Form

The following information must be completed **by the customer:**

Customer Name: _____

Customer Address: _____

Customer Phone #: _____

Serial Number: Left: _____ Right: _____

Warranty Expiration: _____

☐ I request a refund according to the terms of my Purchase Agreement.

☐ Dispensing Fee: $_____ per hearing aid.

At Miracle-Ear, our objective is to provide each customer with the highest quality product, a full aftercare program, nationwide assistance and, above all, maximum benefit from their amplification.

In order for Miracle-Ear to achieve its objective, it is imperative that we receive your comments regarding your reasons for requesting a refund. Please be as detailed as possible. Feel free to attach additional information if needed.

_____

_____

_____

_____

Customer Signature: _____ Date: _____

H.I.S. Signature: _____ Date: _____

Franchisee: _____ Date: _____

Internal Use Only: _____

Acct. Number: _____ *Signature of Approval:* _____