# Financial Policy

______**ASSIGNMENT OF INSURANCE BENEFITS:**

We accept many insurance plans for payment of audiological services. If necessary, a co-pay is paid at the time of the visit.

Hearing aids are sometimes covered in part or whole by insurance carriers. Most often, however, hearing aids are not covered by insurance. We will gladly file for payment directly with your insurance company if hearing aid is a covered benefit. Otherwise, payment for hearing aids is expected at time of dispensing. Various payment options are available. Please ask us for details.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to The Center for Audiology. Copies of my Insurance card and/or driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize The Center for Audiology to release all information necessary to secure payment. **If insurance pays only a portion of the bill or fails to make payment to The Center for Audiology within 90 days, I will be responsible for payment of balance in full at that time.**

_____**MEDICARE PATIENTS- ASSIGNMENT OF MEDICARE BENEFITS:**
I request payment of authorized Medicare benefits to be made to The Center for Audiology for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non-covered services. Co-insurance and the deductible are based upon the charge determined by the Medicare carrier.

Medicare does not cover routine tests such as annual evaluations unless they are medically necessary.

_____**CONSENT FOR TREATMENT:**
I hereby voluntarily consent to such audiological care and treatment, including any diagnostic procedures and tests, to be performed on the patient named herein that the patient's audiologist, his or her associates, assistants and other healthcare providers believe are necessary for the care of the patient. In the course of treatment, I understand and acknowledge that no warranty or guaranty will be made as to the result or cure of treatment.
Strict policies exist and are enforced by The Center for Audiology to ensure that the confidentiality and privacy of patient information is maintained.

_____**HIPAA:** I have received a copy of The Center for Audiology's Notice of Privacy Practices.

OK to call you for appointment reminder: □ Yes □ No OK to mail you information: □Yes □ No

OK to send you e-mail: □ Yes □ No Please note how you prefer to be contacted _________________
*(Please note: We cannot guarantee privacy on email transmissions)*

| ______________________________ | ______________________________ | ____________ |
|---|---|---|
| Signature of Patient/Patient Rep. | Print Name | Date |
| ______________________________ | ______________________________ | ____________ |
| Witness Signature | Print Name | Date |