

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some other insurance, we accept assignment of benefits, but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company states you are responsible for. If this fee is not covered by insurance, it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Grand Hearing Center of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Grand Hearing Center. I understand that verification of insurance coverage obtained over the phone is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I hereby authorize Grand Hearing Center to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Grand Hearing Center to release the medical records of the patient to the patient's referring physician or family physician indicated on the reverse side of this form.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefits, and Release of Information provisions above.

I have read and agree to the terms above and on the reverse side of this form.

Signature of Patient or Legal Representative

Date

Signature of Insurance Policy Holder

Date

Relationship to Patient

Witness (Grand Hearing Center)