HEARING CENTER INC.

Hearing Center Inc. is committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and understanding of our payment policy.

- Payment for services not-covered-by-insurance is due and payable at the time of service or receipt of the product. We accept cash, checks, MasterCard, Visa, Discover and Care Credit.

- If you have insurance, we will file your insurance claims for you as a courtesy. If you do not choose to assign your insurance benefits to Hearing Center Inc. we will collect payment from you at the time of your visit. We will be happy to help you process your insurance claim form for your reimbursement.

- Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for broken appointments and appointments cancelled without 24 hour notice.

-We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. If we are in network with your insurance company we will accept their payment determination.
3. Your insurance company will advise us if you have a deductible or co-pay amount. **We will bill you for these amounts**. There is no way for Hearing Center Inc. to determine how much, if any, co-pay or deductible expenses you may incur as a result of your visit. This is a matter between you and your insurance company.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. **We will bill you for non-covered services.**

- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

- If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

-I authorize release of my medical records to Physicians involved in my Care. I am financially responsible for all charges. All balances are due and payable at the time of service. Hearing Center Inc reserves the right to assess a finance fee of 5% per month on accounts not paid in full within thirty days and patient agrees to pay collection and/or attorney fees.

-I request that payment of authorized Medicare and/or medical benefits be made on my behalf to Hearing Center Inc. for any services furnished me by Hearing Center Inc. I authorize any holder of medical information about me to release to the health Care financing administration and its agents any information needed to determine these benefits.

-I have received the Practices Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I have read the above and acknowledge my understanding of these policies.

Signed___________________________________ Date ____________________