



OUR FINANCIAL POLICY

Thank you for choosing us as your hearing healthcare provider. We are committed to your better hearing. Please understand that payment of your bill is considered a part of your service. The following is a statement of our Financial Policy, which we require you read and sign prior to any service.

All patients must complete our information and insurance form before seeing the hearing healthcare provider. Full Payment Is Due At Time Of Service. We Accept Cash, Checks, And Many Major Credit Cards. We Offer An Extended Payment Plan With Prior Credit Approval.

Regarding Insurance: We may accept assignment of insurance benefits. However, we do require 50% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary the medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to service. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates: Our practice is committed to providing the best service for our patients/clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients/clients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy:

X _____
Signature of Patient or Responsible Party

Date: _____