

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Audiology Experts. A photocopy of my Insurance card (assignment) and a copy of my 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 Audiology Experts to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Audiology Experts within 90 days, I will be responsible for payment of balance in full at that time.

Insurance claims cannot be paid for with Care Credit.

Patient's Name	Signature	Date
-----------------------	------------------	-------------

Patients with Medicare please read and sign below:

I request payment of authorized Medicare benefits to be made to Audiology Experts 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. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Patient's Name	Signature	Date
-----------------------	------------------	-------------

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By checking this box and signing below, I acknowledge that I received a copy of Audiology Experts's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date