PATIENT FINANCIAL AGREEMENT & ACKNOWLEDMENT OF OFFICE POLICIES

CONSENT FOR AUDIOLOGICAL SERVICES

I consent to audiological services at Audiology Experts. This consent encompasses audiological procedures including, but not limited to diagnostic testing and rehabilitative treatment.

PAYMENT POLICY

We are participating providers with most insurance plans. We will file all claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** In order to bill your insurance and to meet filing guidelines, we do ask for a copy of your insurance card and a photo ID.

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized benefits be made on my behalf to Audiology Experts for services furnished to me by the provider. I authorize any holder of medical information about me to release any information needed to determine these benefits and secure payment for related services. Without this release it is not possible to file insurance claims.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to review the NOTICE OF PRIVACY PRACTICES for the office of Audiology Experts, a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

MARKETING

I authorize Audiology Experts to send me educational and/or marketing information on the products and services offered by Audiology Experts. Audiology Experts does **NOT** share your information with third party entities for marketing purposes. If you would prefer **NOT** to receive educational materials and offers from Audiology Experts please check here. ☐

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize and direct Audiology Experts to release confidential medical information to any entity, government agency, or insurance carrier in order to secure payment related to services rendered. Audiology Experts may also disclose my health information to the referring physician, family doctor, and school personnel for transfer of medical care, and follow-up purposes.

In addition to the above, my protected health information may be shared with the following: (e.g. spouse, child):

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Patient/Guardian (if patient is a minor) Signature **Date**

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Please Print Name of Patient/Guardian (if patient is a minor)