FINANCIAL AGREEMENT – HEARING & EAR CARE CENTER, LLC

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees for services rendered or your financial responsibility.

APPOINTMENT – A 24 hour notice must be provided in the event you cannot keep your appointment. Should you not provide this notice a cancellation fee of $45.00 will then be billed to you.

INSURANCE INFORMATION – Each patient is responsible to provide current, complete and accurate insurance information. We will copy your insurance card(s) for your file. Charges for a patient visit for which the patient has provided incomplete, incorrect, outdated or fraudulent insurance information will become the sole responsibility of the patient.

REFERRALS – Some insurance plans require a referral from your primary care physician. It is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit.

CO-PAYMENTS – By our agreement with the insurance companies, we **must** collect your carrier designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

IN/OUT OF NETWORK PLANS – All patients will be responsible for the co-insurance and deductibles. If a hearing test or other service is provided and we do not participate with your insurance company, we will send the bill into your insurance carrier as a courtesy. However, should they not pay the claim within 45 days you will be responsible for the full amount due. Should you receive payment from the insurance carrier, please forward it to our office. In network plan patients will be responsible for any balances due as indicated on their explanation of benefits. Please wait for a bill from our billing office before paying any payments.

MEDICARE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20%.

SELF PAY PATIENTS - Payment is expected at the time of service. If Hearing Aids are purchased and a payment plan needs to be worked out that must be completed and a deposit made before the patient leaves the office.

INSUFFICIENT FUNDS (BOUNCED CHECKS) – If a check is returned to our office for insufficient funds, the original amount plus a $25.00 fee for returned checks will have to be paid by cash, credit card, certified check or money order within 30 days.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges and fees we incur as a result.

I hereby authorize payment directly to Hearing & Ear Care Center, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize Hearing & Ear Care Center to release any information required to secure payment of benefits.

WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, MASTERCARD, DISCOVER & VISA

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient Signature	Date	Witness Signature	Date