HEARING DOCTORS OF OHIO
Dr. Laura L. Sadler, Au.D

FINANCIAL POLICY

Thank you for choosing us as your hearing healthcare provider. We are committed to providing you with all your hearing healthcare needs. Because some of our patients have had questions regarding patient and insurance responsibility for services and products, we have developed this financial policy. You will be given a copy of this agreement for your records. The original will be filed in your chart.

INSURANCE:

- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Billing your insurance is a courtesy service we provide for you. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility.

- Your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits.

- If your insurance company has not paid within 60 days of service, the payment will become your responsibility.
  It is your responsibility to contact your insurance company regarding an unpaid insurance claim.

- It is your responsibility to notify us of any changes and to give us a copy of your current insurance card.

Patient Responsibility for Payment:

- Co-payments, co-insurance and charges that apply to your deductible are due at the time of service. Insurance companies require that we collect your co-pay at time of service.

- If you pay in full for hearing aids not covered by insurance on the date of delivery, you will receive 5% cash or check discount. This does not apply to co-payments or deductibles on testing or other services.

- We accept payment by cash, check, VISA, MasterCard, Discover, and American Express card.

Billing:

- You will receive a monthly statement listing all services, payments, and adjustment, and noting the date your insurance was billed. The statement will specify an amount due from you, and payment is due upon receipt.

- A late fee of 2% APR per month will be added to patient due balances that are outstanding over 90 days.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

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Signature Date