Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payments, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance, it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Alexandria Audiology of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment, or devices delivered to me by Alexandria Audiology, at the rate not to exceed Alexandria Audiology's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive living devices, or fitting examinations.

Release of Information:

I hereby authorize Alexandria Audiology to release any medical information about the patient that is necessary to determine liability for payment and to process any claim for examination, treatment, or devices received by the patient. I also authorize Alexandria Audiology to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this agreement.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Release of Information provisions above.

I have read and agree to the terms above on this form.

____

Signature of Patient of Legal Representative   Date

____

Signature of Insurance Policy Holder   Date

_______________________   ____

Relationship to Patient   Witness (Alexandria Audiology)