Treatment, Consent, and Billing Agreement
Health Insurance Portability & Accountability Act (HIPAA) Acknowledgement

Release of Information: I give permission to *Premiere Speech and Hearing* to disclose all or any part of my medical and/or billing records to any insurance company, third party payer (including my employer, if applicable, for example, in worker's compensation cases), or collection agency which may be responsible for payment of *Premiere Speech and Hearing*'s charges on my behalf or for collecting unpaid balances from the responsible parties. I further authorize such disclosure to any of my other treating health care providers as needed for treatment or billing/payment purposes. *Premiere Speech and Hearing* will release information as permitted by law and/or HIPAA regulations.

Financial Responsibility: In consideration of the services provided by *Premiere Speech and Hearing*, I completely understand and fully agree that I have full responsibility to pay *Premiere Speech and Hearing* for all services rendered. I hereby guarantee full payment of all charges. If my account is referred to a collection agency or attorney, I guarantee payment for all fees, costs, and interest. I also understand that the responsibility for payment may not be deferred for any reason or assigned to any other party. *Premiere Speech and Hearing* may bill my insurance(s), but I remain fully responsible for full payment. *Premiere Speech and Hearing* bills the patient if your insurance/third party does not pay within 90 days. I agree that if I bring any claim or complaint related to billing, and/or my care and treatment, which involves *Premiere Speech and Hearing*, its agents or employees, I will file all claims in Montgomery County, Pennsylvania.

Assignment of Insurance Benefits: I authorize *Premiere Speech and Hearing* to submit a claim to Medicare or other applicable insurance company on my behalf. I authorize payment directly to *Premiere Speech and Hearing* for *Premiere Speech and Hearing* benefits otherwise payable to me. I understand that Medicare does not cover hearing aid related services and therefore Medicare cannot be billed for any hearing aid related charges. I am financially responsible to *Premiere Speech and Hearing* for charges not covered by this authorization, considered non-payable by my insurance(s), non-referred or non-authorized. This covers both primary and secondary insurances, including Medicare, Workman's Comp, and Auto Insurance.

Participation in Insurance Products: I understand that it is my responsibility to verify with my insurance or employer if *Premiere Speech and Hearing* participates with my insurance at the time of service. I relieve *Premiere Speech and Hearing* of any responsibility in reference to non-participation in the insurance or if my services were to be performed by another entity.

HIPAA Acknowledgement: By signing below, I acknowledge that I have had access to *Premiere Speech and Hearing*'s Notice of Privacy Practices.

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Premiere Speech and Hearing*. I understand that healthcare personnel in training may participate in or be present at various times throughout the course of my care at *Premiere Speech and Hearing*. Such personnel are under the supervision of licensed audiologists or speech-language pathologists. I have no objection to the involvement of students in my care and I hereby consent to such involvement.

I authorize *Premiere Speech and Hearing* to send me educational information and/or marketing materials related to office promotions, new products and services that may become available. **Only if you do NOT** want to receive promotional information such as newsletters, holiday cards, birthday cards, flyers, etc… initial here_____

Correct Information: I understand that if I do not present accurate, current and complete billing/insurance information at the time of service, I agree to be responsible for any amounts relating to the bill including full payment of any amounts not covered by insurance. I relieve *Premiere Speech and Hearing* of any responsibility in the event correct information was not provided at the time of service. A copy of my insurance card(s) will be maintained to verify what was presented to *Premiere Speech and Hearing*.

I, _____hereby authorize *Premiere Speech and Hearing* to release any and all medical information in the course of my (or my child's) evaluation and treatment to: _____

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_____ _____

Signature of Responsible Party **Date**