FINANCIAL POLICY

PAYMENTS The office accepts cash, check, Visa, Master Card, American Express, and Discover cards. Payments are due in full at the time services are rendered. A $50 fee for any bounced checks will be applied to the patient balance.

INSURANCE Patients are responsible for notifying the office of any requirements regarding referrals and prior authorizations from your Primary Care Physician. Patients also acknowledge when signing that they are responsible for any and all balances for services rendered not covered by insurance.

HEARING TESTS All diagnostic billing is subject to co-pays and or deductibles per your individual insurance plan guidelines. You will be responsible for any remaining balance after insurance payment.

HEARING AIDS All hearing aid benefits are subject to insurance eligibility and requirements and may have a copay or deductible per your individual insurance plan guidelines. Patients must meet their deductible and out of pocket responsibilities in addition to any coinsurance. Payment for hearing aids is due in full at the time of fitting. Patients are responsible for any remaining balance after insurance payment. Patient also acknowledges that insurance companies may not cover services for the life of the hearing aids and may incur fees for additional appointments which will be outlined in the purchase agreement per their individual contract.

OFFICE VISITS Out of warranty hearing aid services may not be covered under your insurance plan or purchase agreement. Cost for these visits vary depending upon the nature of the visit. An estimate of cost will be provided prior to the appointment. Patient acknowledges that this estimate may vary after assessment of hearing devices at the time of the appointment.

CANCELLATIONS Patients are required to provide a minimum of 24 hours notice for any cancellation or rescheduling of appointments. Failure to provide the required notice will result in a $25 no-show fee.

DOCUMENTATION There is a $15 charge for completion of external forms (testament and certification of hearing loss, etc.). Patients are required to retrieve forms in person, otherwise an additional $10 fee will be applied to receive forms via certified mail.

I sign in acknowledgement that I have read and understand the financial policies as outlined above.

_____ / _____ /_____

Print Sign Date