Financial Policy

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1. Payment of all insurance co-pays, deductibles and non-covered services must be made at time of service.
2. We will bill all primary and secondary insurance company(s) as a courtesy to our patients. However, we are unable to wait for insurance payments. The bill is the patient's responsibility. Note: The delivery of a hearing device system or other ear product will be completed only upon receipt of the entire balance.
3. We will accept payment by cash, personal check and/or credit card.
4. All financial questions will be directed to the facility administrator.

Payment Terms

Hearing Device System Purchases: One-half of the cost of the device(s) must be paid at the time of order, and the remaining balance must be paid at the time of delivery. For patients with insurance, we will bill your insurance company as a courtesy. Any payments we receive from the insurance company will be applied to your patient account balance, and the remaining portion (if applicable) will be refunded to you. Note: The delivery of a hearing device system or product will be completed only upon receipt of the entire balance.

Diagnostic Tests and Other Purchases: Full payment of the fee is due at the time of service. If insurance coverage is available, payment of insurance co-pays, deductibles and non-covered services must be made at time of service.

Workers' Compensation: Patients referred for services under workers' compensation coverage will not be responsible for payment for services or devices if appropriate authorization is provided by the insurance company.

Insurance Billings

Our office will bill primary and secondary insurance companies for covered diagnostic testing and hearing device systems, as noted above. To submit claim forms, we need the following information:

1. Insurance assignment of benefits form completed and signed at the time of service.
2. Copy of insurance card(s), BOTH SIDES, and correct mailing address and telephone number for each insurance company.
3. Proper pre-authorizations from each company as required. We will assist when possible in obtaining the authorizations; however, this is the patient's responsibility.

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1. I understand that Physicians Hearing Services will bill my insurance company as a courtesy (unless required by contract or law). As the responsible party, I guarantee payment.
2. I authorize payment of all benefits for services rendered to be paid directly to the provider of service.
3. I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, employers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
4. The FDA has determined that it is in my best interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing devices.
5. I give permission to receive newsletters or information about upcoming events, specials and articles pertaining to services or products in the clinic.
6. I authorize you to give me reasonable and proper medical care by today's standards.
7. If I have provided a cell phone number as my contact number, I consent to receiving pre-recorded appointment reminder calls at this number.
8. I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.
9. I have read all of the information on this form, agree to the terms above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

Patient Signature _____ Date _____