LISTEN HEAR AUDIOLOGY CENTER

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to services being rendered. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. You are responsible for knowing, if a referral is required. Make sure you know what physicians are in your plan, what facilities are covered, and what ancillary services you must use. If we can be of assistance, please let us know.

3. We file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

4. Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service.

5. **It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision, you will be responsible for the balance.**

6. **Medical insurance coverage is a contract between you and your insurance company**. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

PAYMENT METHODS AND OTHER INFORMATION:

- We accept cash, check, Visa, MasterCard, Discover, or American Express
- Accounts can be set up on payment plans through **Wells Fargo or Care Credit** at no additional cost

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

Signature: _____ Date: _____