Hear in ARIZONA LLC
Life never sounded so good!

Financial Policy

Patient Name: _____

PLEASE READ CAREFULLY

- I agree I am ultimately responsible for the balance of my account for services rendered.
- I request payment of Medicare and/or any other insurance company benefits be paid to Hear in Arizona on my behalf for any services they provide. I authorize the release of my medical information as needed for the determination of benefits payable, and I assume responsibility for any non-covered services.
- I acknowledge I have received the privacy policy for this office.
- 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, health care providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- The FDA has determined it is in my best interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ears) before purchasing hearing devices. I have been advised by the practice and / or its agents about this determination and hereby waive this requirement.
- I give permission to receive newsletters or information about upcoming events, specials, and articles pertaining to services or products in the clinic. To opt-out, please check here [ ].
- I have read all the information on this form. I 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.

I have read, understand and agree to the above information.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian if Patient is a Minor Date

Megan Booth, Au.D. | Debbie Kelley, Au.D.
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