

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 have read, understand and agree to the above information.

- 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 \Box .
- 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.

Patient Signature Date

Legal Guardian if Patient is a Minor Date