HEA HEARING CENTER
Notice of Payment Policies and Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience, we accept major credit cards, checks, or cash.

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Comp, and the Physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the receptionist/registrar.

MEDICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to HEA Hearing Center for any unpaid medical procedures performed now or in the future. I also authorize HEA Hearing Center to release medical information to my insurance company(ies) or agent now or in the future, for claim consideration purposes. I understand that payment for services does not ultimately remain my responsibility.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances due after your insurances(s) has cleared.

DIVORCE DECREES: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

MONIOR PATIENTS: For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or payment by cash or check at the time of service has been verified.

The contents of this document will remain in effect unless revoked by me in writing.

___________________________________	___________________________________
Name of Patient (Print)	Name of Witness (Print)
___________________________________	___________________________________
Signature of Patient	Signature of Witness
___________________________________	___________________________________
Date	Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient