

Patient Agreement



Please read carefully, and sign below:

- The FDA has determined that it is in my best health interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing instruments. I have been advised by my hearing healthcare professional and/or his or her agents about this determination and hereby waive this requirement.
- I give permission to Better Hearing Clinic, Inc. to release information, verbal and written, that may be necessary for my continued medical care, contained in my medical records and other documents, to **those parties identified on the contact/ release of information** or my insurance company for the processing of a healthcare claim. Information that does not identify me as the patient may be used for quality purposes.
- I acknowledge that I have reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy for this office **and a copy is available to me, upon request.**
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchases made. **I understand that my health insurance company may deny payment for services, or pay less than expected. If my health insurance company denies payment, I agree to be personally and fully responsible for payment in full upon receipt of bill. A claim form can be provided upon request for you to appeal with your insurance. I also understand that if my health insurance does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.**
- **If it is determined that hearing aids would be beneficial for your hearing loss, we will contact your insurance to obtain possible coverage. The quote of benefits you are provided does not guarantee payment or verify eligibility but is based on information obtained from your insurance company. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. We encourage you to contact your insurance company to verify as well.**
- **The patient, or their representative, is responsible for obtaining any referrals needed.**
- I hereby authorize direct payment of healthcare benefits to Healthy Hearing and Balance for services rendered.
- I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.
- I hereby authorize, Better Hearing Clinic, Inc. to remove Cerumen (earwax) as allowed by state Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech Language Pathologists. The wax removal fee is \$25.00 per ear or \$50.00 for both ears.
- There will be a \$50.00 charge for Hearing Aids appointments if the Hearing Aids were not purchased from our practice. There may be additional service fees if the Hearing Aids are out of warranty.
- I give permission to receive written correspondence regarding appointment reminders, special events, or new technology from Healthy Hearing and Balance. I understand that my private information will not be sold, shared, or rented to outside parties in ways different from what is disclosed in this statement.

Signature: _____

Date: _____

Signature: _____

Date: _____

SIGNATURE OF PARENT OR GAURDIAN IF PATIENT IS A MINOR