Hearing Care Specialists

Creekside Professional Bldg., Suite 150
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St. Louis Park, MN 55426
(952) 931-9144 – phone (952) 931-9510 – fax
hcs@hearworld.com

Authorization for Assessment: I hereby authorize the Audiologist and/or assistants to administer all diagnostic measures and/or services that may be deemed necessary. I understand no guarantee or assurance can be made as a result of this service.

Authorization for Release of Information: I hereby authorize Hearing Care Specialists to release diagnostic and procedural information for the completion of my insurance claim form. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued audiological and/or hearing aid care.

Authorization of Insurance Benefits: I hereby authorize payment directly to Hearing Care Specialists of the benefits otherwise payable to me but not to exceed the regular charges for these services. I understand I am financially responsible to Hearing Care Specialists for charges not covered by my insurance. This signed agreement is good for one year from signature date.

Medicare Consent: I request the payment of authorized Medicare benefits be made on my behalf to Hearing Care Specialists for any diagnostic measures and/or services deemed necessary. I authorize my holder of medical information to release any information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original.

Billing and Credit Policy: My account will be considered due at the time of treatment. As a courtesy to me, the Business Office will process my insurance if proper information is provided. It is understood that all insurance co-pays be paid at the time of appointment. I will be billed on the current balance of my account regardless of the insurance claim status. I understand that accounts over 90 days old may be referred to a collection agency at which time interest may be charged.

________________________________ Patient/Responsible party

________________________________ Witness

________________________________ Date