PATIENT INFORMED CONSENT FOR HEARING SERVICES

Patient's Name: _____ Date: _____

Your insurance may not pay for all your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. Some healthcare costs are covered, however exceed the negotiated rate or allowable amount based on your individual insurance plan.

The fact that your insurance carrier may not pay for a service does not mean that you should not receive the service.

The insurance company may determine that an item or service /supply is "premium "or an "upgrade" under their applicable payor standards and they may deny the item, service or supply entirely or only make payment for the standard/basic item, service or supply.

Beneficiary Notification of Insurance Coverage

_____ It has been determined through the insurance verification process that I do not have any benefits for hearing aids or hearing aid services. I understand that I have the right to decide, whether or not, to receive these services. If I opt to receive these services, I have been informed that my insurance carrier will not be billed. I am accepting full financial responsibility for the cost associated with the hearing aids and/or services provided.

____ Based on the information associated with my individual insurance plan allowable for services, it is estimated my insurance plan will reimburse $ _____ toward the cost of my selected hearing device(s). This amount is estimated by my individual insurance plan, deductible met to date, co-insurance and/or maximum benefit. According to the information provided by my insurance company. It is estimated that I will be responsible for $_____. This out of pocket estimate is determined by model and style of hearing device that I have chosen, i.e. standard versus Premium, as well as my individual insurance plan allowable and maximum benefit, or services provided. I understand that I am responsible for my estimated deductible, co insurance, co pay, upgrade and any portion my insurance does not pay. I understand that some insurance carriers will pay this clinic directly. If the clinic receives payment, in excess of the purchase agreement amount, the clinic will issue the refund due to me, not to exceed the amount I have paid.

Patient Signature: _____ Date: _____

Hearing Care Provider: _____