CONDITIONS OF FINANCE / SERVICE

As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care at Lakeside Audiology LLC dba Hearing Zone (Hearing Zone), I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient:

Consent for Services: I hereby give consent to Hearing Zone, its audiologists, hearing instrument specialists, and employees to provide hearing health care services to the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that no promises of any particular outcome or successful result have been made.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and separately agree to pay for hearing services rendered to the Patient including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all co-payments, deductibles, co-insurance, and / or non-covered services regardless of amount paid by insurance or third party payors. It is Hearing Zone policy to collect payment in full for services on the day they are rendered unless other satisfactory financial agreements have been made. I understand the Hearing Zone policy and agree to pay in full at the time services are rendered.

I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balance, and a collection fee of 40% of the balance when my account is assigned to a collection agency.

Release of Information: Hearing Zone is required by law to make and keep a record of the Patient's audiological services. Patient records are protected and information is used and disclosed only in accordance with State and Federal privacy laws. Hearing Zone may disclose all or any part of private health information necessary for the purpose of filing claims to and collect payment from health insurance companies, Medicare, Medicaid, Tricare or other government agencies.

Assignment of Benefits: I hereby authorize any and all benefits from insurance companies, third party payors, Medicare, Medicaid, Tricare or other government agencies that are payable to the Patient or on behalf of the patient to be transferred and assigned directly to Hearing Zone.

Privacy Policy Notice: I have received or have been offered a copy of the Privacy Practices Notice.
Brochure given to patient ___Yes ___No (if no, reason)_____

The undersigned has read, had the opportunity to ask questions, understands and agrees to the foregoing, has received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the conditions of this financial agreement and accept its terms.

Date_____

_____ _____

Patient or Patient's Representative | If other than Patient, indicate Relationship

_____ _____

Witness | Reason Patient is unable to sign