Alliance Hearing Center LLC
Alliance Hearing Aids LLC

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Financial Policy and Payment Agreement

The best medical care can be provided only on the basis of mutual understanding. We encourage you to contact our billing office with any questions regarding filing of insurance claims and your financial obligation to Alliance Hearing Center^{LLC} and/or Alliance Hearing Aids^{LLC}. Following are our general financial policies. This this is not an all-inclusive list. You may contact our billing office for special concerns.

Participating Provider – If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and/or co-payment due at the time of service. It is the patient or the insured's responsibility to verify that the audiologists you see are contracted with your particular insurance plan.

Referrals & Authorizations – If your insurance requires a referral for your visit, you are responsible for verifying that the referral &/or authorization is obtained from the primary care physician. If the referral is not received before or on the day of the visit, you are financially responsible for all services rendered.

Deductible – A deductible is a yearly dollar amount you are responsible for based on the type of coverage you have selected. If you have not met your deductible prior to receiving office, audiological or hearing aid services from our providers, you will be responsible for payment of the deductible based on your insurance policy's contract.

Co-Insurance – Your insurance company will only cover services at the level of the benefit you have purchased. In addition to deductibles and co-payments, some policies also hold the patient responsible for a percentage of the cost (Ex. 80/20 where the insurance pays 80% of the allowed charge and the patient is responsible for 20% in addition to the co-payment and deductible).

Diagnostic and Treatment Procedure Consent
Your insurance policy may consider certain diagnostic and treatment procedures as an additional procedure to the office visit charge. Your plan will process this charge according to the terms of your policy (co-payment, deductible, co-insurance will apply). As with all medical services, you are responsible for payment of any portion not covered by your particular insurance policy. You have the right to refuse any diagnostic and treatment procedure and understand that doing so may lead to failure to diagnose and/or treat medical conditions.

Insurance Disclaimer – When benefits are verified most insurance companies will indicate you are eligible but include a disclaimer that states they will not guarantee payment even though you are eligible for benefits at the time of service. You will be responsible for payment of services rendered if your insurance denies payment of benefits for reasons unforeseen at the time they were rendered. Your insurance policy is a contract between you and your insurance company, not the audiologist; however, we will always work with your insurance company to assist you in receiving all benefits due the patient.

Payment Due At the Time of Service – It is your responsibility to provide us with a valid and current insurance card. If you do not have any insurance or did not produce a valid insurance card, or if you are purchasing a hearing aid, assistive listening device, ear plugs or other product, you will be required to remit full payment at the time of service. Patient balances due after insurance processing are payable in full upon receipt of our statement. Special payment arrangements must be discussed with our billing office in advance. For your convenience we accept cash, personal check, VISA, MasterCard, Discover and American Express. There is a $25 fee for returned checks.

I agree that all information provided is current and accurate to the best of my knowledge. I agree to notify the office of any financial changes as soon as possible. I authorize insurance benefits to be paid directly to Alliance Hearing Center^{LLC} and/or Alliance Hearing Aids^{LLC} and I am financially responsible for non-covered services and equipment. The responsibility for payment of services rendered to dependent children of divorced parents rests with the parent seeking treatment. My signature below acknowledges that I have read and agree to the above listed policies.

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Signature of Patient or Legal Guardian Date