SILVERAUDIOLOGY

FINANCIAL POLICY

Our mission is to provide our patients with the highest quality care. To better serve you, we accept most insurance and will help you receive the maximum allowable benefits. To do this successfully, we rely on the information you provide us at the time of service and your understanding of this financial policy. Assisting in the filing of insurance claims is a courtesy we extend to our patients; please let us know in advance if you prefer to file your own insurance claim.

Financial Responsibility

All co-payments, coinsurance, deductibles, fees, payments or noncovered services are due at the time of service. Not all services are covered by all insurance companies—please refer to your insurance policy to determine your coverage. By signing this document, the patient/parent/guardian accepts financial responsibility for the services rendered and may be billed the portion not paid by insurance.

Referrals

Most insurance companies require referrals for our services. If we do not have the required referral at least two days in advance of your appointment, we reserve the right to collect payment from you at the time of services. We will send you a refund if we receive payment from your insurance company. If you are not using insurance, a referral is not required.

Networks

It is your responsibility to know if the services we provide are in-network; as there are multitudes of plans, it is impossible for us to ensure we are providers for your specific plan. We must stress that our financial relationship is with you, not your insurance company.

Noncovered Services

Fees for service not covered by your insurance plan will be due at the time of service. We accept cash, checks and most credit cards.

Release of Information and Benefits

I have read and understand the financial policies of Silver Audiology. I request payment of authorized insurance benefits be made on my behalf to Silver Audiology for services rendered. I authorize the release of patient records to physicians upon request and to my insurance carrier or its agents as required to determine benefits payable for the services rendered.

Authorization of Treatment

I hereby authorize Silver Audiology to administer and perform diagnostic, therapeutic or other services, procedures or treatments that may be necessary for proper care.

Patient/Authorized Signature _____ Relationship _____ Date _____

Patient Name (Printed) _____

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