



INSURANCE ASSIGNMENT FORM

Insurance is a contract between you and your insurance company.

As a service to you, we can accept your insurance assignment. We file insurance claims as a courtesy to our patients. You are responsible for the deductible and co-pays at the time of service. When we receive payment from your insurance company, we will settle any differences. **Medicare will not pay for any hearing aids. Medicare or TRICARE will not pay for the initial office visit with the history portion of your first hearing test. Therefore, you will need to pay for this portion of the service at check-in.**

You are ultimately responsible for the payment of all fees. Our office does not guarantee that your insurance will pay. We perform our insurance billing procedures as a service to you. However, if your insurance claim is denied for any reason, you are responsible for the full amount of the bill. Insurance payments ordinarily are received within 30–60 days from the time of billing. If your insurance company has not made a payment to our office within 60 days, we will request immediate payment from you. We will continue to assist you in receiving payment from your insurance company.

Our office will not enter a “dispute” with an insurance company regarding deductibles, co-payments, covered charges, “usual and customary charges,” etc. We will work with an insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be your responsibility to handle with your insurance company any type of dispute over payment by the company. You are responsible for the timely payment of your account.

This form is also considered the “Authorization to Pay the Doctor.” I hereby authorize payment directly to Silver Audiology of the insurance benefits otherwise payable to me. I understand that I am responsible for any and all costs of diagnostic, therapeutic or other services they perform.

I grant the right to Silver Audiology to release my patient and billing records and other information about my treatment to third-party payers. This is my signature on file.

Any of our fees not reimbursed or paid for by your insurance company will be subject to the terms and provisions stated on our Office Financial Policy Form.

Patient Signature

DOB

Authorizing Signature (if under 18, parent/guardian)

Date

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