Consent for Services, Billing, and Release of Information

Name: _____ Today's Date: _____

Release of Information: I authorize Becker Audiology to release clinical information to bill my insurance company, their authorized representative, state-based insurance/medical coverage agency, or referring agency and to receive pre-admission or to continue the length of service certifications.

Financial Agreement and Assignment of Insurance Benefits: As a responsible party, I agree to pay Becker Audiology for all hearing, tinnitus, and hyperacusis-related services provided. I authorize payment of my insurance benefits directly to Becker Audiology. I understand that I am financially responsible for charges allowed by law that are not covered by insurance.

Statement to Permit Payment of Medical and/or Commercial Insurance Benefits to Provider: I assign the benefits payable to Becker Audiology. I understand that I am responsible for payment of billed charges, even if the insurance provider does not cover the full amount billed.

Fee Information: I acknowledge that fees are charged for services rendered. I understand that I am entitled to fee information, which is available by request.

Non-Covered Services: I understand that some services may not be covered by insurances or third party payers. These services may include, but are not limited to: hearing evaluations, tinnitus and hyperacusis evaluations and treatments, hearing aids, and hearing aid related items.

Medicare/Medicaid: Becker Audiology accepts both, when applicable. Medicare does not cover tinnitus, hyperacusis, or hearing aid services. Medicaid does not cover tinnitus or hyperacusis services. The cost of services not covered by Medicare/Medicaid is the responsibility of the patient/guardian.

By signing below, I certify that I have read and agree to this consent for services, billing, and release of information.

_____ _____

Patient Signature Witness

_____ _____

Parent/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

☐ By checking this box and signing below, I acknowledge that I received or reviewed a copy of Becker Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ _____

Signature of patient or personal representative Date