Hear-Again Hearing Center, LLC
Notice of Financial Policies

Thank you for choosing Hear-Again Hearing Center. Our primary mission is to deliver the best and most comprehensive hearing and ear care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patient as possible. The following is a summary of our payment policy:

PAYMENTS

If a charge is incurred, payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. We accept cash, checks (in-state only), Visa, MasterCard and Discover Card. There will be a service charge from $25 up to $75 for returned checks. We also offer convenient monthly payment options using HealthiPlan and the CareCredit healthcare credit card (subject to credit approval).

INSURANCE

For patients with insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement of hearing aids. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. We accept the following insurances:

Medicare, Medical Mutual, United Health Care, SummaCare, EPIC, TruHearing, Hear.com and Hearing Care Solutions.

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor within 15 business days.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand *Hear-Again Hearing Center, LLC* Notice of Financial Policies. I understand that in the unlikely event that my account becomes delinquent that the unpaid balance will be forwarded to a collection agency. I also understand, that in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

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Patient Name (Please Print) Date of Birth

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Signature of patient or authorized representative Date

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I agree to assign insurance benefits to *Hear-Again Hearing Center, LLC* when necessary (i.e. purchase of hearing aids)

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Signature of insured or authorized representative Date