

**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

When a charge is incurred, payment is required at the time services are rendered unless other arrangements have been made in advance. We accept cash, checks (in-state only), Visa, MasterCard and Discover. 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 first two carriers to maximize your benefit and directly bill them for reimbursement of diagnostic services and / or hearing aids. You are expected to pay your copay on the day of service and / or the complete hearing aid(s) purchase balance on the day of your fitting, then we will then submit a claim on your behalf for your carrier to reimburse you.

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