INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT/HIPAA

ELITE HEARING appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. We do everything within our means to ensure your benefits get paid.

- **While ELITE HEARING makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. I also understand that it is my responsibility to provide full and accurate insurance information at each time of service in order for ELITE HEARING to appropriately bill correct exam, coverage, and co-pays. Ultimately, my final cost share is dependent on the decision of my insurance carrier based on the information I have given to ELITE HEARING. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO ELITE HEARING FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full within 365 days it is my responsibility to pay my invoice and that I will pay collection fees, attorney's fees, court costs, etc. For purpose of collection on delinquent accounts.**
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any payment received to ELITE HEARING for my invoice.
- **I understand there is a $35 fee for all returned Checks** _____ (**Please Initial**).
- I consent to be evaluated by ELITE HEARING for audiologic evaluations and treatments _____ (**Please Initial**).
- **ELITE HEARING does charge a NO SHOW fee. This is authorized by both insurance and VA as patient's responsibility. If a patient does not cancel or reschedule their appointment within 24 hours of the appointment a $110 NO SHOW fee does apply. Repeated short notice cancellation/reschedules also subject to $110 NO SHOW fee. This is waived for sudden illness or inclement weather** _____ (**Please Initial**).
- Follow-up appointments, reprogramming instruments and instrument repairs are not covered by any Insurance and will be out of pocket unless you are covered by a Service Plan _____ (**Please Initial**).
- We will never sell or give away any of your information unless legally binded to do so. For more details, request a copy of our HIPAA policy. I acknowledge that a copy of ELITE HEARING Notice of Privacy Practices is available for review _____ (**Please Initial**).
- I consent to audio recording of visits, used to transcribe what is discussed during my visit to a chart note; this recording is not stored and is deleted immediately once the visit is complete _____ (**Please Initial**).
- PLEASE LIST WHO I authorize ELITE HEARING to release copies of test and audiologic reports to (Primary Care Physician, ENT, VA, WC, Spouse): (required)

  _____ (**Please Print Names**).

By signing below, you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payments. These policies are subject to change or modification without notice.

Please Print Name _____

Signature _____ Date _____