Family Hearing Care

1305 Chestnut Street West Bend, WI 53095
262-338-3553

CONSENT FOR SERVICES, BILLING AND RELEASE OF INFORMATION

Patient Name _____

Release of Information: I authorize Family Hearing Care, LLC to release clinic information to bill my insurance company or their authorized representative, state-based insurance/medical coverage agency or referring agency and to receive preadmission or continued the length of service certifications.

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

Statement to Permit Payment of Medical and/or Commercial Insurance Benefits to Provider: I assign the benefits payable to Family Hearing Care, LLC. Although the insurance provider may not cover all charges, I understand that I am responsible for payment in full of billed charges.

Fee Information: I understand that I am entitled to fee information. By signing this form, I acknowledge that I am aware that fees are charged for services rendered. Information regarding fees is available upon request.

Non-Covered Services: I understand that services rendered to me may not be covered under insurance or payers. These services may include but are not limited to hearing evaluation, tinnitus and hyperacusis evaluation and treatment, hearing aids and hearing aid related items.

Medicare/Medicaid. Family Hearing Care, LLC accepts both of these coverages. Medicare does not cover tinnitus, hyperacusis and hearing aid services. These are the responsibility of the patient. Medicaid does not cover tinnitus and hyperacusis services.

By signing my name below I certify that I have heard and agree to this registration consent.

_____ _____
Patient Witness

_____ _____
Patient/Guardian Signature Date