Hearing & Audiology Services

EXPLANATION OF INSURANCE BENEFITS AND PATIENT FINANCIAL RESPONSIBILITY

Patient Name:_____ Date:_____

Insurance Co/Health Benefit Plan:_____

Model/Purchase Price of Hearing Aid (s):_____ $_____

_____

Estimated Maximum Insurance Payment: $_____

Estimated Patient Co-Pay at Fitting: $_____

Total Balance Owed by Patient at Fitting: $_____

(Insurance Claim will be filed for you at time of fitting)

I understand that I have selected hearing aid(s) that may cost more than the amount paid by my health benefit plan. I have exercised my right to upgrade the hearing aid(s) to the level of technology that best meets my hearing needs and I agree to pay all charges for the aid(s) that are not paid by my health benefit plan.

I understand that the insurance benefits listed are only an **estimate** based on codes, which are for basic digital hearing aid(s). By selecting my hearing instruments(s), I understand that I am responsible for the full purchase price regardless of what my insurance carrier specifies I am responsible for. I also understand that any contractual adjustments taken by my benefit plan will not be applied as a discount or reduction in total purchase price. **I will disregard any such adjustments if they appear on the Explanation of Benefits (EOB) sent by my health benefits plan.**

_____ _____ _____

Patient Signature Date Staff Signature