Center for Audiology, P.C.

Patient Name _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I acknowledge full financial responsibility for services rendered by the Center for Audiology. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-payments, deductibles, and coinsurance amounts. I understand that without health insurance coverage, services rendered must be paid in full at time of service. A $25.00 charge will be added to my account for each returned check. I agree to pay all costs of collection activity including attorney fees, collection fees, court costs, skip tracing costs, and contingent fees to collection agencies for any delinquencies on my account. All insurance information must be provided and verified before services are rendered. If my insurance coverage is unable to be verified, I will be responsible for all charges at the time of service. I acknowledge I must keep my account current and up to date by notifying the office of any address or insurance changes as they occur. I consent that payment of authorized Medicare and other insurance benefits may be made on my behalf directly to the Center for Audiology for any services or products furnished.

Patient or Guardian Signature _____ Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The Center for Audiology's Privacy Practices provide detailed information about how your confidential protected health information may be disclosed and your rights to your protected health information. The Privacy Practices are available at the reception counter, posted in the waiting room, and available on-line. I understand that Center for Audiology reserves the right to change its privacy practices without advanced notice. I hereby acknowledge I have read, understand, and agree to the terms therein. Any questions pertaining to this information have been discussed with staff before signing.

Patient or Guardian Signature _____ Date_____

CONTACT PERMISSIONS

I authorize Center for Audiology to contact me by the following methods:

Yes	No	
☐	☐	**Phone Calls & Voice Messages**
☐	☐	**Third Party Mailings** *(i.e. Information and Materials from Partnering Businesses)*
☐	☐	**Text Messages #_____**
☐	☐	**Emails _____**
☐	☐	**I wish to sign a form allowing another individual access to my confidential medical record information** *(i.e. Spouse, Child, Grandparent)* **Note: Custodial parents have automatic access to child's record**

Patient *or* Guardian Signature _____ Date_____

If you are not the patient, specify your name _____ & relationship to patient _____