CONSTANCE BROWN HEARING CENTERS

Financial Policy

Date_____

Patient Name_____ CBHC#_____

We are committed to providing you with the best possible hearing health care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for our services, equipment and supplies.

Our office participates with many insurance plans. If you are a member of one of these plans, our office will submit a claim for services. If we are not a participating provider for your insurance, upon payment from you, we will provide an itemized receipt for you to submit to your insurance for reimbursement.

It is your responsibility to:

- Give us your current insurance information and provide your insurance card at each visit.
- Pay your full co-pay at each visit.
- Pay any balance not covered by your plan, including any deductibles, copays, coinsurance, and non-covered services.
- Know the benefits, coverage, and terms of your insurance.

Some services may not be covered under your insurance plan. It is your responsibility to pay any balance not covered. You agree to be financially responsible for the fees for all services rendered (as well as equipment and supplies provided). You guarantee payment of the portion of your account for services covered and non-covered, within ninety (90) days of notification of the balance. **You also agree that in the event that you default and do not pay your balance, reasonable costs of collection (limited to no more than forty percent (40%) of the delinquent balance) and/or reasonable attorney fees may be added to the amount due on the account and you agree to be financially responsible for those additional charges.**

Verification of insurance eligibility is not a guarantee of payment. Insurance benefits/coverage can only be determined when a claim is submitted for benefit consideration. Your insurance may only pay for services that it determines to be "reasonable and necessary". In the event your insurance determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" by their program standards, your insurance may deny payment for that service. You will be responsible for payment. Appeal responsibilities will not be assumed by Constance Brown Hearing Centers.

If the patient is a minor, the parent or guardian must sign this form and is responsible for any payment due at the time of service. Bring the necessary authorization to treat and insurance card(s).

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. I agree to be responsible for my insurance deductibles, copays, coinsurance, and non-covered services.

Please print name X _____

Patient/Guardian Signature X_____ **Date** _____