Patient Financial Agreement

There will be charges for services provided. We participate with some insurance companies, as well as Medicare. If you have questions regarding your insurance coverage, please call the office prior to your appointment.

Insurance Claims: You as the patient are responsible for the cost of services provided regardless of insurance coverage. We will file medical claims to your insurance company one time as a courtesy. Therefore, it is necessary to present ALL current insurance cards at the time of your appointment. We must be notified immediately of any changes and please ensure all information is accurate and current. Your coverage is based on the contract between you and your insurance carrier. You must contact your health plan if you have not received notice of payment within 30-45 days of service. It is ultimately your responsibility to verify coverage for your particular insurance plan. If the insurance company denies the claim, you are responsible for the balance.

Patient Financial Responsibility: Your insurance may dictate that we collect co-payments, deductibles, and co-insurance, which is not subject to discounts or adjustments. Co-payment is due at the time of service at every appointment. We accept Visa, MasterCard, Discover Card, check, or cash. There is a $35.00 service charge for any returned check.

Referrals: Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient/parent/legal guardian to obtain needed referrals and updates required by the health plan. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.

Minors: Patients under the age of 18 must be accompanied by a parent or court-appointed legal guardian for treatment. The accompanying parent or adult is responsible for payment.

Please read and initial below:

____ I have read and agree to the terms of the above policies and have received a copy of the Patient Financial Responsibility Acknowledgement.

____ KY Hearing Clinic may bill my insurance company for rendered services.

____ KY Hearing Clinic may collect payments from my insurance company for rendered services.

Signature _____ Date _____

Printed Name _____

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