HearSay Services of Delaware
CONSENT FOR TREATMENT

Patient_____________________________

CONSENT FOR TREATMENT

I consent to treatment at HearSay Services of Delaware and affiliated entities. I grant permission to the audiologist and employees authorized by HearSay to render routine medical care that includes, but is not limited to diagnostic procedures and medical treatment and to carry out all orders deemed advisable by the referring physician. I understand that no guarantee or assurance has been made as to the results that may be obtained.

INSURANCE COVERAGE / ASSIGNMENT OF BENEFITS

I certify that I have no insurance which will pay benefits for this office visit and assume full responsibility for payment **or** I certify that the insurance(s) reported herein for this visit or service is / are a complete listing. I understand that failure to disclose insurance information will result in me being held personally liable. I hereby authorize payment directly to HearSay Services of Delaware for the service.

FINANCIAL RESPONSIBILITY

The undersigned is responsible to HearSay for any and all charges (or amounts based on payment arrangements agreed to by them) that are included during treatment and not paid or otherwise satisfied by insurance or other third party benefits.

In the even that the undersigned fails to make payment of such account, under the condition aforesaid, within thirty (30) days of demand therefore by HearSay, the undersigned shall be obligated to pay reasonable and necessary costs, including the reasonable legal fees and collection expenses incurred by HearSay in pursuing its claim for payment. The undersigned acknowledges that HearSay will take all necessary steps to collect the debt which may include the use of outside services such as collection agencies, attorneys, etc.

MEDICARE ASSIGNMENT OF INSURANCE BENEFITS

Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to HearSay on my behalf for services furnished me. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

CONSENT TO RELEASE INFORMATION

I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations purposes as described in HearSay's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of HearSay's Notice of Privacy Practices

Date___________ Signature_________________________ Relationship________________

Witness____