HearSay Services of Delaware, Inc.

NOTICE OF PATIENT RESPONSIBILITY POLICY

______ SERVICES PROVIDED WITHOUT REFERRAL / AUTHORIZATION

I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services.

______ MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

______ CO PAYS

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-pay **cannot** be waived at any time by the provider of service.

______ DEDUCTIBLES

If my insurance determines that I have **not** met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles **cannot** be waived at any time by the provider of service.

______ AGREEMENT TO PAY:

I have received a copy of this form and have been notified on the above by this provider that I am fully responsible for all services and/or material; and if my insurance does not cover or denies payment for a service or material or both. I understand and agree to be financially responsible.

______ 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

In the event 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.

______ 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 read and understand HearSay's Notice of Privacy Practices. If I would like a copy I may request one from the receptionist.

______ REFUSAL OF SERVICE:

I have decided **not** to have the service/material performed because I am **not** willing to be personally responsible for the payment.

________	______________________________	Self / Parent / Guardian / Other: ____________.
Date	Patient/Guarantor Signature	Relationship (Circle One)
	______________________________	______________________________
	Print Name (Patient/Guarantor)	Witness