# La Cañada Hearing Aids & Audiology

## FINANCIAL POLICY

Thank you for choosing **La Cañada Hearing Aids & Audiology** as your hearing health care provider. Our goal is 100% patient satisfaction.

1. All patients must complete the Patient Information Form and sign our Financial Policy before seeing the Audiologist.
2. Charges for professional services are due at the time of service.
3. We offer a 45-day trial/return on all hearing aids. If you return the hearing aid(s), we will refund your deposit within fourteen days.
4. **Medicare:** Medicare only covers a limited number of professional services, and hearing aids are not covered. If there are services that may be billed to Medicare, we will bill for those services. The patient must cover the balance of the bill.
5. **HMO (Medicare and non-Medicare):** If you belong to a HMO for which we are a participating provider, you only need to pay for the co-pays and deductibles. If we are not a participating provider, we will investigate your benefits to determine whether we can provide service.
6. **Other insurance:** We may accept assignment of some insurance benefits. If your insurance company has not paid your account within 45 days, the balance may be charged to you. If we do not accept assignment, we require 50% of the bill to be paid at the time of service. The balance is your responsibility, regardless of the insurer's payment decision. Please be aware that some, and perhaps all, of the services provided may be non-covered services. To bill your insurance, we require your insurance information and an original claim form.

**Authorization to release insurance information and assignment of benefits:**
I hereby authorize **La Cañada Hearing Aids & Audiology** to furnish any information to my insurance carrier concerning this illness or condition and I hereby assign to the audiologist all payments for medical services rendered and all major medical benefits**. I understand that I am financially responsible for any unpaid balance due**.

X _____ Date: _____
Signature of Patient or Responsible Party

X _____ Date: _____
Signature of Co-Responsible Party