149 Wakelee Avenue
Ansonia, CT 06401
Phone: 203-735-4327
Fax: 203-735-2539

Statement to Permit Payment of Benefits to Provider And Financial Agreement

Name: ____

Authorization to Pay Benefits: I hereby assign benefits to include major medical, private insurance and any other plan to The Hearing Center, LLC. A photocopy of this assignment is to be valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of The Hearing Center, LLC. *Please Note: Benefits if quoted verbally by an insurance company, are not a guarantee of payment.*

Payment Request for Medicare/Medicaid: I request that payment of authorized Medicare/Medicaid benefits be made on behalf of The Hearing Center, LLC for any services furnished to me by The Hearing Center, LLC. I authorize any holder of medical or other information about me to release the Medicare/Medicaid Program and its agents, any information needed to determine those benefits for related services.

Financial Agreement: In consideration of these services rendered by The Hearing Center, LLC at my request and direction. I agree to pay in full any portion of the bill that is deemed to be my responsibility.

Signature of Patient: ______________________________ Date: ________________

If person-signing form is other than patient please complete the following:

Signature: ______________________________ Date: _______________

Please Print: ____

Relationship to Patient: i.e., legal guardian, representative, relative or friend

Name: ____
Address: ______________________________________
____

Please give reason the patient cannot sign form: ____
____