Hearing Resource Center of San Mateo

100 S. Ellsworth Ave., Suites 303 & 711
San Mateo, CA 944001
(650) 579-4470

MEDICAL INSURANCE POLICY

I hereby authorize the disclosure of individually identifiable and protected health information to my stated insurance company for the purpose of billing and obtaining payment for services rendered. I hereby authorize payment directly to Hearing Resource Center for those services which are covered benefits under my medical insurance policy.

I agree to pay all co-pays, deductibles, and percentages due on the date of service. In the case of treatment services and hearing instrument(s) that are not covered benefits under my insurance policy, I agree to make a partial payment to place my order and will complete payment in full due at the time of the hearing instrument(s) fitting.

Although I carry medical insurance, I understand that I am ultimately responsible for payment for services rendered. Should there be a problem with my insurance company not making a payment in a timely manner or paying an amount that I feel is correct, I agree to pay Hearing Resource Center any outstanding balances and settle the differences with my insurance company.

FINANCIAL POLICY

I understand that I am expected to pay for all charges on the date services are rendered, less any amount anticipated by my medical insurance policy in which the Hearing Resource Center is a participating provider.

I understand that Hearing Resource Center accepts American Express, Discover, MasterCard, and Visa as well as personal check, money order, cash and debit card for payment for services and products. If my check is returned by the bank un-payable, I will be charged a $20.00 service fee which will be due and payable within three (3) days along with the amount of the original check.

I understand that if I receive a statement in the mail the full balance of my account is due in thirty (30) days. If my account has an outstanding balance that exceeds ninety (90) days, I understand that I am in a collection status and a finance charge equal to 1% per month may be added to my account. I also understand that I am not eligible to be seen for any future appointments or receive hearing instrument batteries and supplies until my account is paid.

Your signature below is an acknowledgement that you have been advised of our financial and medical insurance policies. You agree that a photocopy of this signed form is as valid as the original.

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Patient Name (Print) Patient Signature

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Date