Horan & Fevold Hearing Clinic, PLLC

1556 N Wenatchee Ave, Suite D
Wenatchee, WA 98801

423 W Third Ave, Suite A
Moses Lake, WA 98837

OUR FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you may have available.

Patients Name: _____

Last **First** **M**

Patients with insurance please read, complete applicable section, and sign below:

Name of Insurance Company: _____

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Horan & Fevold Hearing Clinic, Inc. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Horan & Fevold Hearing Clinic, Inc. to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Horan & Fevold Hearing Clinic, Inc. within 60 days I will be responsible for payment of the balance in full at that time.

_____ _____

Patient's Signature **Date**

Patients with **Medicare** please read and sign below:

I request payment of authorized Medicare benefits to be made to Horan & Fevold Hearing Clinic, Inc. for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

_____ _____

Patient's Signature **Date**