AuD Hearing

www.audhearing.com
262-249-8585

Consent for Services, Billing, and Release of Information

Patient Name: ______________________________ Date: ________________________

Release of Information: I authorize AuD Hearing to release clinical information to bill my insurance company, their authorized representative, state-based insurance/medical coverage agency, or referring agency and to receive pre-admission or to continue the length of service certifications.
Financial Agreement and Assignment of Insurance Benefits: As a responsible party, I agree to pay AuD Hearing for all hearing, tinnitus, and hyperacusis-related services provided. I authorize payment of my insurance benefits directly to AuD Hearing. I understand that I am financially responsible for charges allowed by law that are not covered by insurance.
Statement to Permit Payment of Medical and/or Commercial Insurance Benefits to Provider: I assign the benefits payable to AuD Hearing. I understand that I am responsible for payment of billed charges, even if the insurance provider does not cover the full amount billed.
Fee Information: I acknowledge that fees are charged for services rendered. I understand that I am entitled to fee information, which is available by request.
Non-Covered Services: I understand that some services may not be covered by insurances or third party payers. These services may include, but are not limited to: hearing evaluations, tinnitus and hyperacusis evaluations and treatments, hearing aids, and hearing aid related items.
Medicare/Medicaid: AuD Hearing accepts both, when applicable. Medicare does not cover tinnitus, hyperacusis, or hearing aid services. Medicaid does not cover tinnitus or hyperacusis services. The cost of services not covered by Medicare/Medicaid is the responsibility of the patient/guardian.
By signing below, I certify that I have read and agree to this consent for services, billing, and release of information.

_________________________________ _________________________________
Patient Signature Witness

_________________________________ _________________________________
Parent/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

☐By checking this box and signing below, I acknowledge that I received or reviewed a copy of AuD Hearing's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website(if applicable) and that any revised Notice of Privacy Practices will be made available.

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Signature of patient or personal representative Date