

**Diles Hearing Center**  
275 W. Union Street, Athens, OH 45701  
(740) 594-3571 or 1-800-237-7716

In order to submit a claim for payment of services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

**MEDICARE and WELFARE:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare), its intermediaries or carriers any information needed for this or a related medical claim.

**I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.**

I assign the benefits payable for covered Medicare services to the audiologist or organization furnishing the services or authorize such audiologist or organization to submit a claim to Medicare for payment for me. I request that payment under the medical insurance program be made to **Diles Hearing Center** on any bills for services furnished to me by **Diles Hearing Center**.

**ALL OTHER INSURANCE:** I understand that I am responsible for the office visit co-pay and the full cost of the hearing evaluation at the time of service. **Diles Hearing Center** will submit the hearing evaluation charge to my insurance carrier and that any reimbursement of the test will be made directly to me.

**FINANCIAL OBLIGATION:** I understand that my treatment is payable by me. I also understand that my insurance is a contract between me and the insurance carrier and **not** the carrier and the hearing aid provider and that I am still responsible for all fees. Diles will submit the initial billing to the insurance company to seek reimbursement for you if you have any hearing aid benefits.

Most insurance does not cover the full cost of hearing aids. **Therefore, you, the patient are responsible for the purchase price of the hearing aids.** You will be expected to pay the purchase price at the time of the fitting of the hearing aids. We offer special financing options and will charge interest on outstanding balances after 90 days.

I understand that I am responsible for payment of any charges not covered by insurance. I will uphold any payment agreement negotiated with Diles Hearing Center. I have read the above information and agree to these terms.

*Thank you for your cooperation.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Responsible Party:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_