

**((THE HEARING CENTER))**

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**OFFICE POLICIES**

- 1. ALL PATIENTS WILL BE ASKED TO PRODUCE A VALID PHOTO ID AT THE TIME OF THEIR APPOINTMENT. IF YOU HAVE HAD AN APPOINTMENT WITHIN THE LAST SIX MONTHS, THIS REQUIREMENT WILL BE WAIVED. IF NOT, THE STAFF WILL VERIFY YOUR CURRENT INFORMATION AND IF APPROPRIATE, REQUIRE YOU TO COMPLETE A NEW PATIENT REGISTRATION FORM.**
- 2. ALL PAYMENTS AND CO-PAYMENTS ARE DUE BEFORE SERVICES ARE RENDERED. WE CANNOT BILL YOU FOR CO-PAYMENTS. WE ACCEPT CHECK, CASH, CREDIT CARDS (VISA, MASTERCARD, DISCOVER, AMEX). THE PATIENT/GUARANTOR IS RESPONSIBLE FOR ALL PAYMENTS REGARDLESS OF INSURANCE COVERAGE.**
- 3. IF YOUR HEALTH INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT. IF YOU DO NOT HAVE A REFERRAL AT THE TIME OF YOUR APPOINTMENT, YOU ARE RESPONSIBLE FOR PAYMENT AS YOUR INSURANCE COMPANY MAY NOT PAY FOR YOUR VISIT WITHOUT A REFERRAL.**
- 4. PATIENTS WITH OUTSTANDING ACCOUNT BALANCES WILL BE NOTIFIED 10 DAYS PRIOR TO SUBMISSION TO COLLECTION. ACCOUNTS THAT GO INTO COLLECTION WILL BE SUBJECT TO A 35% COLLECTION CHARGE. ACCOUNTS WITH BALANCES THAT EXCEED 60 DAYS WILL BE SUBJECT TO A LATE FEE OF \$10.00, WHICH WILL THEN BE ADDED TO THE ACCOUNT BALANCE EVERY 30 DAYS THEREAFTER.**
- 5. THERE IS A \$35 CHARGE FOR RETURNED CHECKS**
- 6. IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY NAME CHANGES OR CHANGES IN ADDRESS, PHONE NUMBERS, OR INSURANCE COVERAGE. WE NEED THIS INFORMATION TO BILL YOUR INSURANCE COMPANY, AND IN THE EVENT THAT WE HAVE OUTDATED INFORMATION, ANY ACCUMULATED ACCOUNT BALANCES WILL BE YOUR RESPONSIBILITY.**
- 7. PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT.**

**PATIENT SIGNATURE:** \_\_\_\_\_

**GUARDIAN SIGNATURE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_