Audiology
of New Bern
2111 Neuse Blvd., Suite I
New Bern, NC 28560

ASSIGNMENT OF INSURANCE BENEFITS

Private Insurance:

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 have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to ***Audiology of New Bern***. 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 ***Audiology of New Bern*** to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to ***Audiology of New Bern*** within 90 day, I will be responsible for payment of balance in full at that time.

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Patient's Name Signature Date

Medicare Patients:

I request payment of authorized Medicare benefits to be made to ***Audiology of New Bern*** 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 for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

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Patient's Name Signature Date

PERMISSION TO RELEASE/OBTAIN RECORDS:

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us permission to send a copy to your physician. This release will be in effect until we receive a written notice from you requesting we may no longer forward this information.

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PATIENT/GUARDIAN'S SIGNATURE **DATE**

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