Hear TN
A Sound Decision

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PATIENT NAME: _____ **Date:** _____

Financial Policy / Assignment of Benefits / Privacy Acknowledgement

General 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. I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other hearing health plan to Hear TN for services rendered. A photocopy of my insurance card is to be considered as valid as an original. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hear TN to release all information necessary to secure payment. If insurance pays only a portion of the bill or fails to make payment to Hear TN within 90 days of the date of service, I will be responsible for payment of the full balance at that time.
Signature: _____

Medicare:
I request payment of authorized Medicare benefits to be made to Hear TN for any services rendered to me. I authorize and 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 any information to those carriers in addition to Medicare. 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 any non-covered services. Coinsurance and deductible are based upon the charge determined by the Medicare carrier.
Signature: _____

Healthsprings:
I request payment of authorized Healthsprings benefits to be made to Hear TN for any services rendered to me. I authorize and 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 any information to those carriers in addition to Healthsprings. In Healthsprings assigned cases, the provider agrees to accept the charge determination of the Healthsprings carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and deductible are based upon the charge determined by the Healthsprings carrier.
Signature: _____

I understand that in the event that this account is turned over to an attorney or collections agency for collections, I am responsible for any costs associated with collections. **Initial:** _____

I authorize release of any medical information necessary to process orders and/or request benefit payable to the assigned. **Initial:** ____

I acknowledge that I have read and/or been offered a copy of the Hear TN Corporate Privacy Notice. **Initial:** _

I acknowledge that I grant Hear TN permission to correspond with me via email, telephone, and regular mail regarding hearing health, technology, upgrades, promotions, hearing instruments, devices, and questions or comments regarding my treatment and my patient account with Hear TN. **Initial:** ____

I give Hear TN permission to leave messages and/or discuss with the following people about my hearing health, products and/or services:

_____ Answering Machine/Voice Mail _____Spouse

_____Doctor(s) _____

_____Adult Child(ren) _____

_____Caregiver(s) _____

_____Assisted Living Center or Facility Representative(s) _____

_____Other(s) _____

Signature: _____

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