# PATIENT FINANCIAL RESPONSIBILITY FORM

**Patient Name: _____Date:_____**

Professional Hearing Care requires this form to be signed by all of our patients. We appreciate your cooperation.

**FINANCIAL RESPONSIBILIY:** Professional Hearing Care is happy to assist you with insurance filing. By signing below, you acknowledge the following:

1. I understand that with the exceptions explained below, I am personally responsible for any professional fees I may incur as a patient at Professional Hearing Care.
2. I understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information.
3. I understand that I am responsible for any legal fees incurred if aging charges past 120 days (after final insurance reimbursement, if any) are turned over to collections.

Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which Professional Hearing Care is currently a contracted provider.

**AUTHORIZATION TO PAY BENEFITS:** I hereby authorize payments for professional services provided directly to Professional Hearing Care.

## PLEASE READ AND THEN CHOOSE YES or NO:

If you are unavailable, may we leave medical information, such as reminders, notifications, or scheduling requests on your answering machine/voice mail or with someone at your residence?

**_____YES-information may be left as above**

**_____NO-do not leave any information with anyone**

**Signature of Patient or Legal Guardian:_____**

**Date_____**