HEARD IT THROUGH THE GRAPEVINE AUDIOLOGY, PC
Consent Form

CONSENT FOR TREATMENT

I consent to receive audiological services at Heard It Through The Grapevine Audiology, PC. This consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as I receive audiological care at Heard It Through The Grapevine Audiology, PC.

Signature___________________________________ **Date** _____________

Parent/Guardian Signature________________________________ **Date** ___________

Consent of Release for Protected Health Information (PHI)

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Signature___________________________________ **Date** _____________

Financial & Insurance Policy

Patient ________________________________ DOB ____________________

Regarding Insurance
We may accept assignment of insurance benefits for diagnostic services. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary to medical insurance. If your insurance company has not paid your account in full within 60 days from the date of service, the balance will be automatically billed to you. (Balance may be billed to patient prior to the 60 day period if insurance denies the claim.) Payments are due upon receipt of invoice. I understand that if I have a balance that was unpaid, and the balance is submitted to a collection agency, our relationship will be terminated, and my medical care will be referred to another physician.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, All co-pays & deductibles are due at the time of service. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Children of Divorced Parents: Responsibility or payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of Heard It Through the Grapevine Audiology, PC.

Accounts that are over 90 days past due will be charged a $45 late fee.
If your insurance requires a referral we cannot start the appointment until it is received.
Accounts with checks that cannot be processed due to insufficient funds will be charged a $45 fee.
Patients that do not attend their appointments and do not call 24 hours in advance to cancel are subject to a $50 fee.

Usual and Customary Rates
Our practice is committed to providing the best service for our patients/clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I have read and understand the financial & insurance policy. I will notify Heard It Through The Grapevine Audiology, PC of any changes in my insurance information.

______________________________________ ____________________
Signature of Patient or Responsible Party Date

Updated December 17, 2021