SHOW LOW
2600 S. White Mountain Rd.
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

FINANCIAL POLICY

We Accept: CASH, CHECKS, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS

INSURANCE PATIENTS: As a courtesy, Audiology, Inc. will bill my Insurance Company, but I understand that I am ultimately responsible for all co-pays, co-insurance, and deductibles for professional services provided and/or purchases rendered. The balance is my responsibility whether my insurance company pays or not. I am aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program, AHCCCS and/or other medical insurances (Cerumen [earwax] removal, hearing aids and/or hearing aid services, etc...). *It is my responsibility to know what my insurance policy says.*

I authorize and direct my insurance company to send all checks or drafts relating to hearing healthcare services provided by Audiology, Inc. and it's attending audiologists to 2600 S. White Mountain Rd. Show Low, AZ 85901 or 620 S. Central Ave Ste. B, Safford, AZ 85546. Any payments for services rendered by Audiology, Inc. and it's attending audiologists, are to be applied toward the balance of my account. I understand that if my insurance company pays me directly for services or purchases rendered, that I will in turn pay Audiology, Inc. the full amount owed as soon as payment has been received by me. I authorize the release of any medical information necessary to process insurance claims or to obtain predetermination.

SELF PAY: Payment is due at the time of service for all self-pay patients.

RETURNED CHECKS: The amount of the check plus a $25.00 fee will be due within 5 days of a check being returned. If the original amount owed plus the $25.00 fee is not paid within 5 days, the full amount may be turned over to collections.

AUTHORIZATION TO DISCUSS: Do you authorize Audiology, Inc. to discuss your care or treatment with any party besides yourself? Yes or No
If yes, please complete the information below.

Name:________________________________ Phone #: _______________________ Relationship:_____________

Name:________________________________ Phone #: _______________________ Relationship:_____________

UNPAID BALANCES AND COLLECTION POLICY: After your insurance company has paid the claim for services rendered, if there is a balance due, you will receive a statement for 2 consecutive months. If payment is not made and payment arrangements are not made, your account may be turned over to a collection agency or you may be taken to small claims court, depending on the circumstance. Any dispute with regard to payment of an unpaid debt shall be subject to the laws of the State of Arizona. We reserve the right to refuse service to anyone.

____ Date_________________________
Signature of Patient or Responsible Party

SOCIAL SECURITY NUMBER:___________________________________ DATE OF BIRTH:_______________________
Responsible Party