STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Sally W. Fodero, Au. D.

Patient Name:____ Date:_______________

INSURANCE

While we make every effort to verify insurance coverage, it is not always possible. Many insurance companies have additional stipulations that may affect your coverage; therefore, it is your responsibility to:

1. BRING YOUR INSURANCE CARD TO EACH VISIT
2. NOTIFY OUR OFFICE OF ANY CHANGES TO YOUR INSURANCE
3. KNOW YOUR CO-PAY AND BE PREPARED TO PAY AT EACH VISIT
4. KNOW YOUR INSURANCE COMPANY BENEFITS AND COVERAGE
5. DETERMINE IF DOCTOR(S) ARE NETWORK PROVIDERS PRIOR TO FIRST VISIT
6. PAY FOR ANY AMOUNTS NOT COVERED BY YOUR INSURANCE, INCLUDING CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME SERVICE IS RENDERED

I have read the above policy regarding my financial responsibility. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to New Hampshire Hearing and Balance. I agree to pay New Hampshire Hearing and Balance the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature:____ Date:_____________