FUTURE HEARING
of San Leandro
The Future of Hearing is Here.

OFFICE POLICY

Thank you for choosing Future Hearing of San Leandro as your hearing health care provider. The following is a list of our office policies. All prospective patients must read, sign and date this form at the bottom of the page before being seen. You may request a copy of this policy for your records.

1. All fees are due at the time of service.

2. If you are being fit with traditional hearing aids, a deposit of 50% is required at the time of the order, and the balance is due upon receipt of the hearing aid(s), unless special arrangements are made. We offer a 30-day trial/return policy on all new traditional hearing aids. If you return the hearing aid(s) within this period, we will refund the amount paid to us.

3. Medicare: Medicare only covers a limited number of professional services. <u>They do not cover hearing aids</u>.

4. HMO/Other Insurance: Our office is Out of Network. If you have hearing aid coverage through your health insurance, contact them directly to determine your particular benefits. Have them confirm that you may be seen at our office, and find out about co-pays and deductibles. Get this in writing if possible. Payment for hearing devices and/or services is due and payable on the date received, whether or not you have insurance coverage. As a courtesy we will submit the claim to your insurance to initiate the reimbursement process, but if necessary, you are responsible for any follow-up required to obtain personal reimbursement from them.

5. Appointments: Please help us serve you better by making an appointment for services. As a courtesy to other patients, we ask that you are on time for your appointment. If you are unable to keep your appointment, please contact our office 24 hours in advance to cancel or reschedule.

Authorization to release insurance information and assignment of benefits:
I hereby authorize Future Hearing of San Leandro to furnish any information to my insurance carrier concerning this illness or condition, and I hereby assign to them all payments for medical services rendered and all major medical benefits. I understand that I am financially responsible for any unpaid balance due.

WE ACCEPT VISA-MASTERCARD-DISCOVER-AMERICAN EXPRESS

x_____ Date:_____
Signature