Hearing & Speech Associates, Inc.
12500 Highway 41 N, Suite 6
Evansville, Indiana 47725

Phone: 812 425 1500
Fax: 812 425 0587

evansvillehearing.com

FINANCIAL POLICY

Whether you are new to our office or we have had the enjoyment of serving you over the years, we encourage you to be aware our financial policies. Please read all information carefully, sign the form and return it to our front office staff.

For your convenience, Hearing & Speech Associates will work directly with you in filing Medicare, Medicaid and private insurance as needed. Please remember to bring a current copy of your insurance card(s) the day of your appointment so that the correct information can be obtained.

Our office is happy to participate in Medicare, Medicaid and most private insurance plans but we do not know the details of the coverage and benefits for your particular plan. Therefore, please be familiar with your policy and know what is required. Some of the requirements are as follows:

- Written referral from your family physician or specialist, ****Medicare & Medicaid do require a written referral. Your doctor's office may fax this referral to our office at 812.425.0587 prior to your appointment****
- Prior Authorization
- Annual deductibles that apply

Patient Balance: You, the patient will be responsible for the following:

- Services that are considered not covered by your insurance carrier
- CoPay, deductible and balances remaining after your insurance company have paid. (Percentage of the allowed amount that is your responsibility.)

Payment in full is expected within **15** or **30** days from the date on your first statement advising you of the patient balance due. Patient accounts not paid in full by the due dates will received a notice of the past due account giving a 10 day notice before the delinquent account will be turned over to an outside collection agency. Please update our office immediately if financial difficulties arise so that we may make arrangements for a payment plan.

Payment Options: We accept cash, personal check, VISA, MasterCard, Care Credit, Wells Fargo and Discover cards. Please be aware that our office does enforce a $25.00 fee for all checks returned for insufficient funds.

Acknowledgment and Authorization: I have read, understand and agree to the above policies. I authorize the release of any medical information necessary to process insurance claims on my behalf. I authorize payment of all medical benefits due me to be made directly to Hearing & Speech Associates, INC. I agree that I am ultimately responsible for payment for all services rendered, regardless of any insurance I may have.

Signature: _____ **Date:**_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **Yes** **No**

May we leave a message on your answering machine at home or on your cell phone? **Yes** **No**

May we discuss your medical condition with any member of your family? **Yes** **No**
If YES, please name the members allowed: _____

_____

This consent was signed by: _____
Printed Patient Name or Responsible Party

_____
Patient Signature or Responsible Party **Date**

_____
Relationship to Patient (If other than patient)

Hearing & Speech Associates, INC.

Megan Grable, Au.D, CCC-A ~ Kara McCormick, Au.D. CCC-A ~ 12500 Highway 41 N, Suite 6, Evansville, IN 47725 ~ 812.425.1500

"No Show" and "Cancellation" Policy

Dear Patient,

At Hearing and Speech Associates, Inc., our goal is to provide quality audiological care in a timely manner, therefore, we have implemented a no show and cancellation policy in effect as of ***May 13th, 2019***, which enables us to better utilize available appointments for our patients in need of our services. The following policy is with regard to patients who fail to keep their scheduled office visit appointment, diagnostic visits; including established and new patient appointments or fitting and orientation appointment.

Please be courteous and call Hearing and Speech Associates, Inc. promptly if you unable to attend an appointment. This time will be reallocated to another patient in need of our services. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely audiological care.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule/cancel your appointment. This will make the appointment time available to someone else. Our scheduling number is: 812.425.1500.
2. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this to be a missed appointment. If you call and cancel your appointment less than 24 hours in advance, it will be considered a missed appointment. **If you have more than two missed appointments in one year, we reserve the right to discontinue providing service to you, and you will be notified in writing.**
3. If you are late for an appointment, you may be asked to reschedule. This is to respect the next patient's scheduled appointment and to remain on time.
4. As a courtesy, an automated appointment reminder system has been implemented. You will be notified by phone, email, or text message of your appointment. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

To cancel or reschedule appointments call the office at (812) 425-1500. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

By signing below you agreed that you have read and understand the implemented policy above.

We appreciate your patronage.

_____
Patient Signature

_____
Date

_____
Patient Printed Name

Hearing and Speech Associates

evansvillehearing.com

MEDICATION LIST

Patient Name**:**_____DOB_____

MEDICATION	DOSAGE	FREQUENCY	REASONING

Allergies:_____

_____

Patient Signature:_____

Date:_____