Hearing Associates of Dothan, LLC

200 Grove Park Lane, Suite 800
Dothan, AL 36305
(334) 702-4327 Fax: (334) 702-4328 Hearing.Associates@Hotmail.com

Billing and Financial Policies

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Hearing Associates of Dothan, LLC for any furnished services. I authorize Hearing Associates of Dothan to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents, which might provide coverage to me.

All Services are the Responsibility of the Patient: Hearing Associates of Dothan will gladly bill my primary insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed. **If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement.** I understand that when my insurance company requires a referral from my primary care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand that I am financially responsible for all service and material co-pays, deductibles and for any non-covered services at the time of service.

I hereby agree and consent as follows: If my account becomes delinquent it will be placed with Prim & Mendheim, LLC, for collection and subject to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of one and one-half percent (1.5% percent per month; 18% per annum); (2) in addition to the outstanding balance, I will be responsible for reasonable collection costs, attorney's fees, and costs of court incurred in the collection of same, whether such outstanding balance is satisfied prior to or after initiation of a lawsuit, or after a judgement has been entered in a lawsuit; and (3) any lawsuit or legal proceeding resulting from the outstanding balance and debt shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and objections to said jurisdiction. By signing below, I affirmatively acknowledge that I have read the same before signing. Furthermore, I can be contacted regarding my balance on my cell phone and I hereby waive any and all state and federal personal property exemptions, wage exemptions, and homestead exemptions of my state of residence and state of operation in the event of judgement, levy, or garnishment. Finally, if I reside in Florida I hereby waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance.

Returned checks: There is a $35 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Patient's Name (printed):_____ Date of Birth: _____

Signature: _____ Date: _____

(Responsible party signs if patient is a minor or is unable)