CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

- **Consent for treatment**
  I authorize Hanover Audiology PLLC to provide audiological treatment to myself and/or my dependent.

- **Assignment of Benefits**
  I request that payment of authorized Medicare, Medicaid or applicable private insurance benefit be paid directly to Hanover Audiology for services provided under their care.

- **Release of medical information**
  I authorize Hanover Audiology PLLC to release necessary medical information to my insurance company, its agents, or any third party payor in order for payable benefits for these services to be determined.

- **Financial Responsibility**
  I understand that co-pays are due at the time of service.

  I understand that Hanover Audiology PLLC will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all expenses and up to 33.33% of collection costs.

- **Referrals/Authorizations**
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. I understand that if I do not have a referral no services will be rendered until the referral is received or until I sign a waiver acknowledging acceptance of financial responsibility, payment in full will be required on the day of your appointment.

- **Returned Checks**
  Our office will charge $35.00 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

_____ _____

Patient Name (Printed) Date

_____ _____

Signature of Patient or Responsible Party Relationship to patient