Blackstone Valley HEARING CENTERS

Elizabeth A. Finch, Au.D.
Board Certified Audiologist

1044 Smithfield Avenue
Lincoln, RI 02865
401-725-5798

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Blackstone Valley Hearing Centers. A photocopy of my Insurance card (assignment) and a copy of my drivers license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Blackstone Valley Hearing Centers to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Blackstone Valley Hearing Centers within 90 days, I will be responsible for payment of balance in full at that time.

Patients Name _____ Signature Date _____

MEDICARE PATIENTS:

Patients with Medicare please read and sign below:

I request payment of authorized Medicare benefits to be made to Blackstone Valley Hearing Centers for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non- covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Patients Name _____ Signature Date _____