Please Read and Sign

Permission to leave a message:

I give my permission for the staff of BalanceMD / Indiana Hearing Specialists to leave messages concerning imaging studies, labs or other medical information related to my condition on the following devices or methods: (circle) Cell/Home Phone Voicemail Work Voicemail Email Other:_____

Patient Signature_____Date_____

Permission to give information to the following:

Name_____Relationship_____

Name_____Relationship_____

Fax Privacy Waiver

BalanceMD / Indiana Hearing Specialists utilizes Electronic Medical Records (EHR) which includes faxing of medical records. I understand that my medical records may be transmitted electronically and received by a third party in error. In the event that should occur I absolve BalanceMD / Indiana Hearing Specialists of all liability.

I give BalanceMD / Indiana Hearing Specialists consent to fax my records for the purposes of treatment, payment or healthcare operations. Written withdraw of this consent may be given at any time.

Patient Signature_____Date_____

Financial Agreement 07/19

Assignment of Benefits:

I hereby assign all medical benefits to include major medical to which I am entitled, including Medicare, private insurance and another plans to BalanceMD / Indiana Hearing Specialists. This assignment will remain in effect until revoked by me in writing. I agree to pay BalanceMD / Indiana Hearing Specialists the charges for all medical services rendered. I shall also be responsible for any attorney fees, court costs and/or collection fees which may amount to more than 35% of the services rendered. Any fees occurred to collect the debt for services rendered will be at my expense.

I understand that I may be charged a $10.00 statement fee on partially paid or overdue balances.

I agree that if BalanceMD / Indiana Hearing Specialists sends a refund check to my address of record, and I fail to cash the check within 180 days, the refund may be donated to a charitable organization.

Authorization of Release of Information:

I hereby authorize BalanceMD / Indiana Hearing Specialists to furnish such professional information as may be necessary to complete my insurance claim from the medical records compiled during my treatment and are hereby released from all legal liability that may arise from the release of the information requested.

I have read and understand BalanceMD / Indiana Hearing Specialists' financial policy and agree to abide by its guidelines. I understand, regardless of insurance coverage, I am responsible for all financial obligations resulting from care provided by BalanceMD / Indiana Hearing Specialists. This policy supersedes any previous policies, written or verbal. It may be amended by the practice without prior notification to the patient.

Signature states that you have read and understand our financial policy.

Patient Signature_____Date_____

Acknowledgment of BalanceMD / Indiana Hearing Specialists Privacy Practice

I have been given the opportunity to review and/or receive a copy of BalanceMD / Indiana Hearing Specialists Notice of Privacy Practice. By signing I am giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Signature_____Date_____