CREDIT POLICY

PATIENT RESPONSIBILITY:

Our practice is committed to providing the best treatment for our patients. Patients are responsible for all charges resulting from treatment provided by their Audiologist. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at your next visit. All patients must complete the Patient Intake form before seeing the Audiologist.

PAYMENT ARRANGEMENTS:

New and Established Patients: Payment is due in full at the time of service, unless prior arrangements have been made.

Insurance companies do not guarantee payment. If there is a balance due after insurance pays, payment is due within 30 days of the first billing. Accounts with balances over 90 days will be assessed a processing fee each month.
We accept Visa, Mastercard, Discover Card, checks, cash and money orders.

REFERRALS:

Many insurance carriers require referrals from your Primary Care Physician before you receive care from a specialist. It is your responsibility to obtain a referral or prior authorization if your medical coverage requires either.

INSURANCE BILLINGS:

Please be aware that some or perhaps all of the services you receive may be non-covered services and not considered reasonable and necessary under your insurance plan. In this instance, you will be responsible for payment.

Medicare: Our Audiologist is a participating provider. Please note that under current guidelines, Medicare does NOT provide coverage for hearing aid(s).

Oregon/Washington Welfare and Oregon Health Plan: We are **NOT** a participating provider.

Providence Network Insurance: If your insurance uses the Providence Network, they will most likely not pay for services. We are not a contracted provider with Providence Health Plans or Providence Preferred Oregon Network. If this applies to you we will collect fees at the conclusion of your visit today.

I have read and received a copy of this credit policy. I accept this policy for my treatment with my Audiologist.

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Patient Signature or Guardian if patient is a minor Date