



Hearing, Speech & Deaf Center

**PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT**

Your signature below forms a binding agreement between Hearing, Speech & Deaf Center (HSDC) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

**Our Medical Insurance & Private Pay Policy**

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are accountable if your insurance company declines to pay for any reason.

- Private pay patients -Full payment amount due at the start of the appointment.
- Inform HSDC of the current address and phone number for the Patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the start of the visit.
- When HSDC receives an explanation of benefits (EOB) from your insurance company, any charges (e.g., Denied Service Coverage, Deductible, Co-Insurance) will be billed to you.
- Pay any additional amount owed within 15 days of receiving a statement from our office.

**Attendance and Cancellation Policy**

All appointments must be cancelled with at least 24 hours' notice.

- A missed appointment/no show fee of \$25.00 may be charged for all appointments that are not cancelled with 24 hours' notice, except in the case of emergency or illness.
- Patients who are more than 15 minutes late to an appointment will be marked as a "no-show" and will need to reschedule.
- If a client misses more than 20% of their appointments, they may be placed on "Walk-in" only status, meaning that they will not be given a routine time for scheduled appointments.
- If ongoing attendance is poor or problematic, services may be terminated.

**Returned Check Policy**

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the patient's Responsible Party will be responsible for the original check amount in addition to a \$ 25.00 Service Charge. Once notice is received of the returned check, HSDC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance—in addition to the \$25.00 check Service Charge.

**Non-Payment on Account**

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that HSDC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 50%, all court costs and attorney fees, and a collection fee added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Name \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_