ADVANCED AUDIOLOGY CARE

107 Newtown Rd, Danbury, CT 06810 • (203) 830-4705
901 Ethan Allen Highway, Ridgefield, CT 06877 • (203) 438-1868
131 Kent Road, New Milford, CT 06776 • (860) 210-0286
488 Main Ave, Norwalk, CT 06851 • (203) 857-9218
22 Old Waterbury Road, Southbury, CT 06488 • (203) 262-4270

Thank you for choosing Advanced Audiology and Hearing Aid Services for your hearing healthcare needs.

Please be advised that our audiologists are not in-network with your insurance carrier for any hearing aid services. Therefore we will not bill your insurance company for your hearing aids. Hearing aids are an out of pocket charge and must be paid in full by the time hearing aids are received. You may, however, choose to submit to your insurance company for reimbursement for a portion of the out of pocket costs. If you have out of network benefits for hearing aid purchases please request that the billing department send you a statement for your aid purchase. This statement will include the following: your procedure code and your diagnosis code. The audiologist who takes care of you will be listed as the rendering provider. The practice listed on the statement will be Advanced Audiology and Hearing Aid Services. You will not be provided with a tax identification number. The statements are generated weekly and will arrive by mail.

The following payment options are available to you: check, cash, Visa, MasterCard, American Express, and Discover. Pre-payments for hearing aid services are also accepted. We can also recommend the Newtown Savings Bank, for a short term, low interest financing option. If you would like to finance your hearing aids through Newtown Savings Bank, we can provide you with additional information.

On the day of your hearing aid fitting (the day you receive your hearing aids), you will be expected to have paid for the hearing aid(s) in full, or have a bank check for payment of that visit.

Please direct any questions about the payment process for hearing aids to the billing department at 203-830-4703.

Again, thank you for letting us be providers of your hearing healthcare needs.

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices
Informed Consent
Practice Financial Policies
ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810
131 Kent Road New Milford, CT 06776
488 Main Ave, Norwalk, CT 06851

901 Ethan Allen Highway, Ridgefield, CT 06877
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Privacy Officer (203) 830-4700 ext. 8265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.
I authorize the person(s) listed below to discuss my medical information. **If you do not speak English please list the name and phone number of who we can call to discuss your medical information with.**

_____ _____
Name & phone number **Relationship to Patient**

_____ _____
Name & phone number **Relationship to Patient**

_____ _____
Emergency Contact Name & Phone Number **Relationship to Patient**

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

I understand that I will be charged a $25-$50 **NO-SHOW** fee if I do not show up at my scheduled appointment. In order to avoid the **NO-SHOW** fee an appointment needs to be cancelled 24 hours prior.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

_____ _____
Signature (Parent or Guardian please sign if Patient a Minor) **Relationship to Patient**

_____ _____/_____/_____
Please Print Name **Date**

_____ _____/_____/_____
Patients Name (if Minor) **Patient's date of birth**