pacificaudiologyclinic

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www.pacoregon.com

Billing Policies

By initialing the lines below, I hereby acknowledge and consent to:

_____ **Payment is required at the time of service**. If your insurance requires a co-pay, payment will be due at the time of your appointment. We accept personal checks, cash, Visa and Mastercard. There will be a fee of $25.00 for any returned checks.

_____ **We will bill your insurance carrier; however, we do not accept responsibility for ensuring preferred provider status with your insurance company.** You will be billed for unpaid balances after your insurance processes. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement of a disputed claim. You are responsible for payment of your account and any unpaid insurance claims.

_____ **Upon purchase of a hearing aid, payment is required in full.** We will then bill your insurance and issue you a refund if one is owed. If payment arrangements must be made, please discuss this with your provider. We work with Wells Fargo and Care Credit for financing options. Please discuss this with your provider for more details on plans we offer. There is a $500 minimum charge to utilize these financing options.

_____ **Client balances that are 60+ days past due will be assessed a $10 per month service charge.** If payment arrangements must be made, please contact our office. Accounts carried over 90 days without payment may be turned over to a collection agency. In that event, the contingency fee assessed will be added to the principal and service charges due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. If your account is turned over to a collection agency, it may affect your credit rating. In most cases, the only information released to a collection agency about a treatment would be the patient's name, basic contact information, the nature of the services provided, and the amount due.

_____ **We require a 24-hour notice of cancellation. If a 24-hour notice is not given, a late cancellation or no-show charge of $100 may be assessed.** Insurance companies will not be billed for this fee; it is the patient's responsibility. If you need to cancel your appointment during non-business hours, please leave a message on our voicemail. In case of illness, please contact our office as soon as possible to re-schedule your appointment.

Your signature below indicates your understanding of the information provided above. If you wish, our office will provide you with a copy of this policy.

Signature _____ Date _____

IF WE ARE BILLING YOUR INSURANCE, PLEASE READ AND SIGN BELOW

I authorize Pacific Audiology Clinic or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the provider. I understand that billing of insurance companies is done as a courtesy by Pacific Audiology Clinic, LLC and that I am financially responsible for all charges.

Signature _____ Date _____