Ruud's Hearing Aid Service

PHILIP RUUD BC-HIS
Hearing Instrument Specialist
OR Lic# HAS-P-924167; WA Lic# HA00000290
541-276-3155 800-678-3155 Fax 541-276-0607
29 SW Dorion
Pendleton, OR 97801

To all patients,

Federal law now requires that we obtain your permission to contact you by phone, leave messages and market information to you (advertising). Please review the following statements and circle the appropriate choice. This form will remain in your file. If you wish to rescind this permission we require the request to be in writing.

Thank you.

I may be called at home. **Yes No**

I may be called at work. **Yes No**

I may be emailed. **Yes No**

Ruud's Hearing Aid Service may leave messages at home. **Yes No**

Ruud's Hearing Aid Service may leave messages at work. **Yes No**

Ruud's Hearing Aid Service may send text messages. **Yes No**

Ruud's Hearing Aid Service may send marketing. **Yes No**

Ruud's Hearing Aid Service may call with marketing messages. **Yes No**

Ruud's Hearing Aid Service may discuss my account with my spouse/children/legal rep. Yes No

Ruud's Hearing Aid Service may call my legal representative. **Yes No**

Ruud's Hearing Aid Service may discuss my medical results with my spouse/children/legal rep. **Yes No**

Last Name_____First Name_____Middle_____

_____Date_____

Signature of Patient: (Parent or Guardian if patient is a minor)

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND RELEASE OF MEDICAL INFORMATION

PAYMENT IS EXPECTED AT TIME OF SERVICE. Payment may be made by cash, check, VISA, MasterCard or Care Credit. Third party payment or assignment is generally accepted for services. Any deductible, co-insurance, or co-payment is payable at time of service.

PAYMENT GUARANTEE: The undersigned agrees, whether signed as a patient or guarantor to guarantee payment of the account in accordance with the standard rates and terms of Ruud's Hearing Aid Service. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Ruud's Hearing Aid Service has a specific contract with other third party payers. I further understand that any balance remaining, after insurance approves or denies payment; will be my responsibility to pay.

In the event that the charges are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay in addition to the charges for services and treatment received, all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, skip tracing costs, and court costs.

I hereby AUTHORIZE Ruud's Hearing Aid Service to RELEASE ALL MEDICAL INFORMATION to all my insurance carriers, other third party payers, including Medicare or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Worker's Compensation or other insurance purposes.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize the payment of any insurance or other medical benefits directly to Ruud's Hearing Aid Service. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

_____Date_____

Signature of Patient: (Parent or Guardian if patient is a minor)

_____

Name of Patient if signed by Parent or Guardian