Audiology Group
of Northern Colorado

Welcome to Audiology Group, LLC. Please take a few minutes to review the following information.

Please sign all necessary fields.

PATIENT RESPONSIBILITIES:

Co-payments: We do not bill for copayments. Co-payments are due at the time of service.

Referrals: If we are billing Medicare, we need a referral from your primary care provider before scheduling.

Cancellations: Please provide us 24 hours advance notice of cancelling your appointment.

Return Checks: A $20.00 fee will be assessed on returned checks.

If you have Federal Medicare, we will submit your claim for you.
If you have any other insurance, we will provide forms for you to submit.

If services provided are not a covered benefit you will be responsible for any charges incurred.

If you do not have insurance, we expect payment at the time of service. We accept **VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.**

A one-time $25.00 rebilling fee will be assessed to accounts after 90 days. Accounts over 90 days are subject to collection. If your account is placed in full collection or if we write off a bad debt, you will be dismissed from this practice. Refunds will be returned in the same form tendered.

I have read and agree to the above.

Date: _____ **Signature:** _____

Print Name: _____

You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or e-mails, using an e-mail address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I/We have read this disclosure and agree that we may be contacted as described above.

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Date: _____ **Signature:** _____

Release of (Medical) Records

I authorize this clinic to furnish audiological information regarding the treatment of my current hearing status to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related inquiries).

Date: _____ **Signature:** _____