PRACTICE CONSENT FORM
PLEASE REVIEW IT CAREFULLY.

I hereby authorize Dr. Mimi or designated staff to take molds, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my hearing needs for proper hearing health care.

Upon such diagnosis, I authorize Dr. Mimi to perform all recommended treatment mutually agreed upon by me and to employ such assistance needed to provide care.

I understand that my health plan or payer of my hearing benefits may pay less than the actual bill of services; I understand that I am financially responsible to pay in full for all services provided. I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my health care plan.

I authorize release of any information concerning health care, advice and treatment provided for the purpose of evaluation and administration of claims for insurance benefits.

I hereby authorize payment of hearing health plan / insurance benefits directly to the clinic.

I agree to be responsible for payment, in full, of all equipment and services rendered by the Clinic on my behalf. This includes deductibles, co-insurance, contract exclusions, non-authorized services deemed by my insurance provider to by non-covered expenses and any remaining balances after my insurance provider makes its payment. (Please see the Payment Agreement for our full payment terms.)

Patient name _____

Signature _____ Date _____

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