

**ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY**

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Advantra	Healthcare Preferred
Aetna US HealthCare (**Diagnostic Only)	Humana (All Products)
Blue Cross/Blue Shield of Kansas City (All Products)	Kansas Medicaid
Champus/Tri-Care	Medicare
Cigna Healthcare	United HealthCare (** Diagnostic Only)
Coventry Healthcare	Health Access
Freedom Network	Blue Cross/Blue Shield of Kansas

*** Indicates contract for Diagnostic Services only through this health plan, and not currently contracted for Hearing Aids.*

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy lists a required co-payment, I am responsible for payment of this amount at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. **If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc accepts payment by cash, personal check, money order/cashiers checks, Mastercard, Visa, and CareCredit. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

Patient/Guardian Signature

Date

2/2004