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Daniel Island
HEARING CENTER
Hear Well, Live Well

843.971.4199
843.971.4292 fax
899 Island Park Drive 200A
Daniel Island, SC 29492

Financial Policy
As a courtesy, we will be happy to file the claim for your hearing evaluation if we participate with your insurance company and if the insurance company will accept electronic claims. We will file claims to Medicare when Medicare is your primary insurance. We are unable to file secondary claims to Medicare.
We are unable to file claims to Medicare Railroad. We do not automatically file claims for hearing aids, as coverage is not typical and requirements vary greatly. If you feel you may have some hearing aid benefits, please advise us so we can help you to clarify what benefits you may have and how to best proceed. **You are responsible for any charges not covered by your insurance.** Medicare will cover an initial, one-time hearing evaluation, when hearing loss is the primary symptom or diagnosis. An annual deductible and a co-payment of 20% apply. If you have a supplemental policy, it may cover your co-pay or deductible. **Repeat and annual hearing evaluations are typically not covered by Medicare. The fee for a non-covered repeat or annual hearing evaluation is currently $65.00. You will be asked to sign an additional form, required by Medicare, in this circumstance.**

Use and Disclosure
I hereby authorize Daniel Island Hearing Center to use my healthcare information and to disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for the related services.

Assignment of Benefits
I hereby authorize payment of insurance benefits to be made directly to Daniel Island Hearing Center for services rendered. Additionally, I authorize Daniel Island Hearing Center to release any information necessary to secure payment of insurance benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Privacy Practices
I hereby acknowledge that I have read and understand the Notice of Privacy Practices for Daniel Island Hearing Center, LLC & do not wish to receive a copy. (Please ask Practice Manager if you would like a copy for your records.)

Lifetime Medicare B and/or Independent Insurance Signature Authorization
I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services OR authorize such physician or organization to submit a claim to Medicare or independent insurance company for payment to me.

By signing below, I agree to the following:
I understand that I am responsible for all charges that are not paid by insurance. I understand that balances are due upon receipt of statements and Finance Charges may be applied to account balances that are not paid within 30 days of initial statement date. Furthermore, I hereby authorize:

- the use of this form on all my insurance submissions
- release of information to all my Insurance Companies
- Daniel Island Hearing Center, LLC to act as my agent in helping me obtain payment from my Insurance Companies
- direct payment to Daniel Island Hearing Center, LLC
- that a copy of this form be used in place of the original
- that I will be on the Daniel Island Hearing Center mailing list but that my information is not sold or shared with any other firms, companies or entities

SIGNATURE _____ **DATE** _____