Uthe Hearing Aid & Audiology Centers, LLC
Phone: 515-278-2413 Fax: 515-278-5875

☐ 807 Broad St. Grinnell, IA 50112
☐ 2478 E Euclid Ave DSM, IA 50317
☐ 3839 Merle Hay Rd Ste 200 DSM, IA 50310
☐ 404 Jefferson St. Pella, IA 50219
☐ 1208 N Lincoln St. Knoxville, IA 50138

Financial Agreement

Payment Method

Select the options that apply: ☐ Self-Pay ☐ Insurance

Insurance

Primary Insurance: _____

Member Name: _____ DOB: _____

Secondary Insurance: _____

Member Name: _____ DOB: _____

Patient is responsible for maintaining this information

Financial Policies and Procedures

Authorizations and Referral: If an insurer requires an authorization and/or referral, patient and/or policyholder is responsible for obtaining an order from a physician. This order must be received prior to service, or patient and/or policyholder will be financially responsible for payment at time of service.
Participating Provider: Copayments, deductibles, and coinsurance are due prior to service. Patient and/or policyholder is responsible for verifying participation of a provider with his/her insurance policy. This policy may not include coverage for all services. Therefore, if applicable, patient and/or policyholder will be billed for any outstanding balance. Payment in full is due within fourteen (14) calendar days of billing.
Non-Participating Provider: Payment in full is due at time of service. As a courtesy, Uthe Hearing Aid and Audiology Centers, LLC, per patient request, may submit a claim(s) to an insurer(s). Unless otherwise specified, this insurer(s) is responsible for reimbursing the cost(s) of a covered service(s) directly to the patient and/or policyholder.
Verification of Benefits: Uthe Hearing Aid and Audiology Centers, LLC strongly encourages patients and/or policyholders to confirm insurance benefits prior to service. As a courtesy, Uthe Hearing Aid and Audiology Centers, LLC, per patient request, may contact a patient's insurer to verify benefits. Verification of benefits serves as guidelines of coverage from an insurer(s) prior to the date of service. **Therefore, this verification is not a guarantee of payment.**
Payment Terms and Conditions: Methods of payment include cash, check, and credit (Visa, Mastercard, American Express, Discover, CareCredit) or debit card. Returned and/or cancelled checks will incur a fee of $35 per occurrence. A late fee of $25 will apply for each subsequent monthly statement for all unpaid balances commencing sixty (60) calendar days from the date of service or date of initial billing. Delinquent accounts will accrue additional charges including, but not limited to, reasonable attorney fees, court costs, and collection agency fees. By agreeing to accept this policy, patient acknowledges Uthe Hearing Aid and Audiology Centers, LLC reserves the right to release any patient information deemed necessary to an outside collection agency to assist their staff and attorneys in the collection of this debt

By signing below, I acknowledge I read and understand the financial policies and procedures given above, and I agree to the terms and conditions.

Patient Name: _____ Date: _____

Patient/Representative Signature: _____ Relationship: _____