INSURANCE AUTHORIZATION FORM

ASSIGNMENT OF BENEFITS

Full authorization is hereby given to Medicare to make payments directly to Hearing Associates, PC for all medical services provided to me by Hearing Associates. I also authorize any insurance carriers I have in addition to Medicare to make payments directly to Hearing Associates for all medical services provided to me by Hearing Associates, PC. I understand that I am financially responsible to Hearing Associates for any balance not covered by my insurance policy.

_____
Patient / Policy holder signature

RELEASE OF MEDICAL RECORD INFORMATION

I authorize the release of medical information requested by insurance companies with whom I have coverage as may be deemed necessary for payment of medical claims.

_____
Patient / Policy holder signature

Date:_____