Beverly Hills Hearing Center
9100 Wilshire Blvd. Suite 310 E
Beverly Hills, Ca. 90212
P. 310-276-8585 F. 310-276-2045

PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, and medical services by the staff of Beverly Hills Hearing Center.

FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorize my insurance benefits be paid directly to Beverly Hills Hearing Center. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically co-payments and charges for services which are not covered by my insurance.

COPAYMENT POLICY: If applicable, at the time of check in, I will be required to pay a co-payment, if I do not pay my co-payment; I understand that my visit may be cancelled.

INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

REFERRAL/AUTHORIZATION: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without prior authorization from my provider I may be financially responsible for the services rendered and insurance may not cover the relevant services.

RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to provide health care, to process my medical claims, and for other purposes relating to the health care operations. Additional information is provided in our Notice Of Privacy Practices.

FEES FOR PATIENT'S HEALTH INFORMATION: I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

Patient Name: _____ Date: _____