Hearing Healthcare Center

3101 N. Green River Rd., Ste. 510, Evansville, IN 47715 * (812) 303-4300 * www.HearBetterEvansville.com

Payment Policy

Thank you for choosing us as your hearing care provider. We are committed to providing you with affordable and quality audiological services. Because some of our clients have had questions regarding client and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space allotted. A copy will be provided to you upon request.

1. **Insurance.**
   We do not participate in any insurance plans, including Medicare. Payment in full is expected at each visit. Accepted forms of payment are cash, check, credit cards, and HAS debit/credit cards.
2. **Claims Submission.**
   We do not file insurance claims on your behalf. We will provide you with reimbursement claim forms and assist you in any reasonable way to help get your reimbursement submitted. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.
3. **Non-Payment**
   If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted, unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this clinic. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative audiological care. During that 30-day period, our audiologist will only be able to treat you on an emergency basis.
4. **Missed Appointments**
   Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our clinic is committed to providing the best treatment to our clients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Client Name (printed): _____

Signature: _____ Date: _____

Relationship to client (if a minor): _____