INSURANCE RELEASE

Patient Name: _____ Birthdate: _____

I certify that the information given by me in applying for payment under Medicare (Title WVIII of the Social Security Act) and/or other Medical Insurance is correct.

I hereby authorize the release of any medical information necessary to process any claims submitted on my behalf of the Hearing Speech & Deaf Center.

I request that payment under Medicare and/or any other Medical Insurance be made directly to the Hearing Speech & Deaf Center and authorize them to submit a claim to Medicare and or any other medical insurance carrier on my behalf.

_____ _____

Authorized Signature/Relationship Date

MEDICARE POLICY ON HEARING TESTING

Medicare will only pay for services that it determines to be reasonable and necessary under section 1962(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for the services. Medicare will deny payment for your hearing evaluation for the following reasons:

1. Not referred by a referring or attending physician

Or

2. Medicare has already paid for a hearing evaluation

Beneficiary Agreement:

I have read the above statement and understand that the Hearing Speech & Deaf Center cannot guarantee payment from Medicare on any hearing test. Therefore, if Medicare denies payment I agree to be fully responsible for payment.

_____ _____

Beneficiary/POA Signature Date

OP 6-2 Rev 12/31/04