371 State Route 17M, Suite 7
Monroe, NY 10950
(845) 395-0300

PERMISSION FOR TREATMENT

Permission for Treatment: Permission is hereby granted for employees or agents of Lyric Audiology (collectively, the "Provider") to render the patient named below such treatment as is deemed necessary within the Provider's Scope of Practice.

Authorization for Release of Information: The Provider (through its employees or contracted copying services) may disclose the patient's medical record and account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

Financial Agreement: (Please initial as applicable)

______________ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to Lyric Audiology all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

______________ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

______________ **Self-Paying Patient:** I have been informed that Lyric Audiology , does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this amount.

I have read the above Financial Policy, I have understood it, and I agree to it.

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Print Patient's Name

______________________________ ______________
Signature (Patient, Patient Representative) Date

______________________________ ______________
Signature (Witness) Date

______________________________ ______________
Signature (Financially Responsible Party) Date

______________________________ ______________
Signature (Witness) Date