



FINANCIAL & PRIVACY POLICY

Patient Name: _____

PLEASE READ CAREFULLY

- I agree I am ultimately responsible for the balance of my account for services rendered.
- I request payment of Medicare and/or any other insurance company benefits be paid to Central Florida Speech & Hearing Center (dba Lakeland Hearing Care) on my behalf for any services they provide. I authorize the release of my medical information as needed for the determination of benefits payable, and I assume responsibility for any non-covered services.
- I acknowledge I have received the privacy policy for this office.
- I give permission to this practice to release information, verbal and written contained in my medical record and other related information to my insurance company, health care providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- The FDA has determined it is in my best interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ears) before purchasing hearing devices. I have been advised by the practice and/or audiologists about this determination and hereby waive this requirement.
- I give permission to receive newsletters or information about upcoming events, specials, and articles pertaining to services or products in the clinic. To opt out, please check here [].
- I have read all the information on this form. I certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.
- I understand that Central Florida Speech & Hearing Center (dba Lakeland Hearing Care) is partnered with the University of South Florida and other educational facilities and may provide observation opportunities to students and staff members. I give permission for student and staff observation of my appointments.

I have read, understand and agree to the above information.

Patient Signature

Date

Legal Guardian if Patient is a Minor

Date