Professional Hearing Center

PATIENT WAIVER FOR APD SERVICES

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan. As such, your insurance will not pay for these services. **Therefore, the costs listed below are in addition to the services that will be billed through your insurance** (Services billed to insurance include the following CPT codes: 92620 $218.98 and 92621 $53.85)**.**

Although not covered by your health insurance, these services are an important part of your overall evaluation and care, and we recommend that you receive these services as part of your current treatment plan. However, since the services listed are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your audiologist are listed below:

- Interpretation of evaluation and formal report **$130**
- Follow-up appointment for counseling on results and treatment recommendations **$120**

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*