Patient Obligation Agreement

Company: _____ Provider: _____

Patient Name: _____ Patient ID#: _____

Insurance Company: _____ Insurance Plan _____

This agreement is a supplemental document, in addition to the Purchase Agreement, for your Hearing Aid purchase. This document provides a summary of the estimated amount we expect your insurance company to pay on your behalf, for your Hearing Aid(s).

When we verified your hearing benefits with your insurance company, they informed us that the information they provided is an estimate, and payment is not guaranteed. By signing this agreement, you are stating that you understand and agree to pay any amount that your insurance company does not pay on your behalf, up to the total amount of the hearing device purchase.

Allowed Amount (Standard Device): $ _____

Patient Deductible Amount: $ _____

Patient Coinsurance (____%): $_____

Patient Copayment: $ _____

Hearing Aid Total: $ _____

Price Difference Above Standard Device*: $ _____

***Upgrade Amount: See below, if applicable**

Expected Insurance Reimbursement:

$ _____

Total Patient Responsibility:

$ _____

Most insurance companies will only cover a "Standard Hearing Aid." Based on the results we have examined from the test we have conducted, complaints or symptoms you have described or reported, and discussions between yourself and your Provider, you are agreeing that you would like to receive a Hearing Aid that is considered an above standard product and you are consenting to pay the amount above what your insurance company considers a standard hearing aid.

$ _____ Estimated Price of Standard Hearing Aid
(per benefit information provided by your insurance company)

$ _____ Total Price of the Hearing Aid you are electing to purchase

$ _____ Difference between a Standard Hearing Aid and Hearing Aid Total (Upgrade Amount)

By signing this agreement, you are stating that you are electing a Hearing Aid that is not a standard device, and you understand your insurance company deems the upgrade amount as a non-covered charge. Hereby stating that you will pay the non-covered charge (i.e., Upgrade Amount) and any other patient responsibilities as indicated by your insurer. _____ **(Patient Initials**

)I have read and understand the above statements regarding estimated plan benefits, Standard and Upgraded Hearing Aids (devices/products), limitations and my payment obligations.

_____ _____ _____

Print Name **Signature** **Date**