HEARING ASSOCIATES, PC

RECORD OF SIGNATURE ON FILE

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Account #

ASSIGNMENT OF BENEFITS

Full authorization is hereby given to Medicare to make payments directly to Hearing Associates, PC for all medical services provided to me by Hearing Associates. I also authorize any insurance carries I have in addition to Medicare to make payments directly to Hearing Associates for all medical services provided to me by Hearing Associates, PC. I understand that I am financially responsible to Hearing Associates for any balance not covered by my insurance policy.

_____
Patient / Policy holder signature

RELEASE OF MEDICAL RECORD INFORMATION

I authorize the release of medical information requested by insurance companies with whom I have coverage as may be deemed necessary for payment of medical claims.

_____
Patient / Policy holder signature

Date_____