Billing Authorization

Statement to Permit Payment of Any Health Insurance Benefits to Supplier, Physician, or Patient.

Name of Insured: _____

Name of Patient: _____

I understand and agree *that I am responsible for the payment of all charges incurred in result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.*

I understand and agree *that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.*

I herby authorize *payment directly to Johnson's Hearing Centers, for any services rendered to me by Johnson's Hearing Centers or any of its authorized agents.*

I authorize the release of all medical information to the insured's health insurance carrier that is:

1. acquired in the course of my examination or treatment and
2. which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Johnson's Hearing Centers or any of its authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

_____ _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE DATE