PATIENT AUTHORIZATION FORM

PATIENT FIRST NAME	MI	LAST NAME	GENDER	DOB (MM/DD/YYYY)
			○M ○F	

HOME ADDRESS	CITY	STATE	ZIP

PHONE	SECONDARY PHONE	EMAIL

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Audiology and hearing aid services provided by ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. are billed to health care insurance companies as an added service. To agree to this service, read the following statement, then sign and date below.

I authorize ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. to directly bill my health insurance on my behalf. Furthermore, I authorize the health insurance company to pay benefits on my behalf directly to ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. for items and services provided to me by ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC.

I agree to notify ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. immediately of any changes in insurance coverage. I agree to pay all amounts owed to ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. that are not covered by my health insurance company, including applicable co-payments and deductibles for which I am responsible. I understand that if ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. is out of network with my insurance, I have the option to get my care at either an in-network or an out of network provider. I understand that when receiving care out of network for products or services covered by my benefit plan, my insurer may impose a higher deductible and higher copayments than if I received services from a network provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for understanding my insurance benefits and for the balance of my account.

I authorize any holder of medical or other information about me to release to ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. or its billing agent any information for this and any related health claim. Furthermore, I authorize ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. to release medical or other information about me for the purpose of obtaining payment from my health insurance company and their agents and assignees. Such records may be released to any individual or entity authorized to receive such information.

I agree to permit a fax or other copy of this form to serve as an original. Upon request, a copy of this form may be sent to my health insurance company and their agents or assignees. ASHLEY ENGLE, AU.D., AUDIOLOGY & HEARING AID SERVICES, LLC. will keep the original form on file. I understand that this authorization will remain in effect until revoked by me in writing.

BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

SIGNATURE	TODAY'S DATE (MM/DD/YYYY)

SIGN

**If signed by someone other than the patient, I attest that I have the authority to sign on behalf of the patient.*

Ashley Engle, Au.D.

Audiology & Hearing Aid Services, LLC

Ashley Engle, Au.D., CCC-A, F.A.A.A.
Vincent Lustig, Ph.D., CCC-A, F.A.A.A.

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