Financial Policy

Louisville Family Audiology

4003 Kresge Way, Suite 225
Louisville, KY 40207
Phone: (502) 893-3342
Fax: (502) 893-3343

Date:_____

Thank you for choosing Louisville Family Audiology as your hearing healthcare provider. Our providers are committed to providing you with the best audiological care available at a cost that is both fair and reasonable. Please read this financial policy and indicate your understanding and agreement with your signature and date.

1. OUT OF POCKET EXPENSES: Insurance companies do not cover miscellaneous supplies or administrative work, nor do we contract with insurance companies for the coverage of hearing aids and related services/supplies. All out of pocket expenses are required to be paid in full at the time of service.
    a. SUPPLIES – Any supplies you receive from our office must be paid in full at the time of service.
    b. HEARING AIDS – We will not bill insurance for services related to a hearing aid consultation or service. Hearing aid consultations are a courtesy and you will not be billed for those appointments. If you do purchase a hearing aid(s), we will provide you with a copy of the encounter detailing your visit to submit for reimbursement to your insurance company.
    c. MEDICAL RECORDS – Will be happy to furnish you with a copy of your medical records. There is a 2-week turnaround time on all medical record requests, and you will be charged based upon time and volume.
2. NO SHOW FEES: We require a 48 hour notice for proper cancellation or rescheduling of your appointment. Failure to provide such notice will result in a $50.00 charge.

Patient Acknowledgement of Financial Responsibility.

We require every patient read the preceding financial policy and sign the following Financial Agreement prior to seeing one of our medical professionals. Your clear understanding of this financial policy is important. Please speak to a member of our billing department if you have any questions.

I hereby guarantee payment of charges for ***(patient name)*** _____.

Signature: _____

Print name: _____

Relationship to patient: _____ Date: _____