Hear Well Again Centers
800-879-3432/610-359-0200/215-654-5395
fax 610-356-6180

ACCOUNT PAYMENT POLICY

I understand that all charges incurred by _____ are my responsibility. Any balance remaining after my primary insurance payment will be my responsibility. Any balances billed to my major medical carrier will be paid by me in full upon receipt of my insurance check.

DATE:_____ SIGNATURE:_____

I request that any payment due to Hear Well Again Centers be paid to Hear Well Again Centers directly for any services rendered to _____. I authorize the above named provider to release to the Social Security Administration or its Intermediaries or carriers any information needed to process claim or related Medicare claims. This authorization is to also apply to any and all private insurance claims I may incur.

DATE:_____ SIGNATURE:_____

TESTING PERFORMED (for HWAC use only)

_____ 92551 SCREENING (PT)
_____ 92552 SCREENING (PT AIR)
_____ 92553 PURE TUNE (A&B)
_____ 92555 SRT
_____ 92556 SRT & DISCRIM
_____ 92557 COMPLETE AUDIO
_____ 92562 LOUDNESS BALANCE
_____ 92563 TONE DECAY
_____ 92567 TYMPANOMETRY
_____ 92577 STENGER - SPEECH
_____ 92569 REFLEX DECAY
_____ 92568 ACOUSTIC REFLEX
_____ 92588 OAE
_____ 92550 TYMP & ACOUSTIC REFLEX
_____ 99214 OFFICE VISIT/CONSULT
_____ 92560 CAP
_____ 92626 AURAL REHAB
_____ 92625 TINNITUS ASSESSMENT
_____ 92627 ADDITIONAL 15 MIN. AURAL REHAB

DIAGNOSIS (for HWAC use only)

1. Code:_____ Description_____
2. Code:_____ Description_____
3. Code:_____ Description_____