CENTRAL ILLINOIS HEARING. LTD. Rev. 7/14

Assignment of Benefits

I hereby authorize and direct my insurance carrier (including Medicare, private insurance and any other health/medical plan) to issue payment directly to Central Illinois Hearing, Ltd. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. It is my understanding that any money received over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am responsible for any and all charges not covered by my insurance company any fees assigned by a collection agency or an attorney. A photocopy of this assignment is to be considered as valid as original. This will remain in effect until revoked by me in writing.

Signed _____ Date _____

Authorization to Release Information

I hereby authorize Central Illinois Hearing to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used in processing insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Central Illinois Hearing, Ltd. On behalf of myself and/or my dependents, and understand that my making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

Signed _____ Date_____