Assignment of Benefits

Thank you for choosing an AMG™ network office to be your healthcare provider. To serve you best, we ask that you read and sign this form to: (1) allow us to submit a claim along with your medical information to your managed care plan, insurance company, or other Program you have identified as potentially providing coverage for hearing aids and service you receive (any of which will be referred to as the “Plan”) ; (2) to assign your benefits under the Plan for payment directly to us; (3) to acknowledge that you understand and agree to pay us for any applicable co-payments, deductibles and co-insurance under your Plan; and, (4) if the plan allows, to acknowledge that you understand and agree to pay for the difference between the price of the hearing aid(s) and/or services and the amount of the benefit collected from your Plan.

1. **Assignment of Benefits**
    - **a.** I confirm that the information I have provided about my Plan (or other medical benefits) is accurate, complete and correct.
    - **b.** I request that any payment, paid by the Plan be made on my behalf to amg™
    - **c.** I authorize amg™ (or its agent) to file an appeal on my behalf for any denial of payment or adverse benefit determination made by the Plan.
    - **d.** If the Plan will not direct such payment to amg™, I agree to forward all payments which I receive, on account of covered hearing aids or services provided, that I have not yet paid for.
    - **e.** I authorize amg™ to release all medical or other information about me to the Plan necessary to determine and pay any benefits under the Plan.
2. **Financial Responsibility**
    - **a.** I understand and agree that I am responsible to pay amg™ for any co-payment on the day of my first office visit (or on the first day I receive services covered by the plan.)
    - **b.** I understand and agree that, if allowed under the Plan, I am responsible to pay for any difference between the price of the hearing aids and services which I purchase and the amount of the benefit paid by the plan. Where the Plan covered the hearing aids or service and prohibits this practice, I will only be charged cost-sharing amount in accordance with my Plan’s benefit terns.
    - **c.** I understand and agree that if any payments made by the Plan to amg™ exceed the expected payment amount so that is an overpayment, I will be notified and offered a refund, not to exceed the amount I have paid.
    - **d.** I understand and agree that if I decide to purchase hearing aids and services that are not covered under my Plan, I am responsible to pay the full price of the hearing aids and services.
    - **e.** I understand and agree that the provisions in this document apply and extend subsequent visits and appointments.

_______________________________________ _____________________________________ _________________

Patient/person Legally responsible Relationship to Patient Date