NEWPORT-MESA AUDIOLOGY
BALANCE & EAR INSTITUTE

Newport Beach
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Newport Beach, CA 92663
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INSURANCE PAYMENT RIDER

This Insurance Payment Rider is entered into by and between Newport-Mesa Audiology, Inc., (hereinafter referred to as Facility) and you, the Patient (hereinafter referred to as Patient) or Patient's legal guardian with respect to the following:

BILLING/PAYMENT: Patient agrees that he/she is financially responsible for payment of all services rendered by Newport-Mesa Audiology. Patient understands that Facility will bill Patient's insurance carrier as a courtesy only, and there is no understanding that Newport-Mesa Audiology will agree to accept only what Patient's insurance company pays, as payment in full. Patient understands that, as a result of such billing, the Patient's insurance carrier may send payments directly to the Patient for services provided to the Patient. Should any action be taken to enforce this agreement the prevailing party shall be entitled to the reasonable attorney fees and costs incurred in enforcing this agreement. This Agreement shall be governed by and interpreted and construed in accordance with the laws of the State of California with venue expressly agreed to the Superior Court of the County of Orange.

1. I as the Patient agree to:
    a. Upon receipt of said insurance check, deposit said check;
    b. Within ten (10) days, remit payment directly to Newport-Mesa Audiology along with any and all Explanation of Benefits (EOB); and,
    c. Payments should be mailed to:

Newport-Mesa Audiology, Inc.
500 Old Newport Blvd., Suite 101
Newport Beach, CA 92663
Attention: Patient Accounts

2. ***CONSENT TO RELEASE INFORMATION:*** Patient expressly agrees that Newport-Mesa Audiology may:

    a. Bill Patient's insurance carrier for any and all services rendered, if applicable;
    b. Obtain any and all information from Patient's insurance carrier regarding such billing including, without limitation, whether Facility's bill has been accepted, whether payment has been made directly to the Patient, when payment occurred and the amount paid; and,
    c. Release any and all information as requested by Patient's insurance carrier in accordance with billing practices and procedures.

3. ***Treatment & Payment Agreement:***
    a. I authorize examination and treatment for this and all following provider visits.
    b. I authorize and release any medical information necessary to process insurance billings.
    c. I authorize payment and assignment of my insurance benefits to Newport-Mesa Audiology.
    d. I am personally responsible for supplying accurate and current insurance information.
    e. I understand that I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this agreement to serve as an original.

I,_____, agree to the terms as set for the above. Dated:_____

_____ _____
Patient/Legal Guardian Signature Name Printed

_____ _____
Newport-Mesa Audiology Representative Signature Name Printed