amplifon Hearing Health Care

General Upgrade Form

Patient Name:	(Auto-Populate)	Date of Birth:	(Auto-Populate)
Sycle ID:	(Auto-Populate)	Date of Service:	(Auto-Populate)
Insurance Plan:	(Auto-Populate)	Clinic Name:	(Auto-Populate)

Description of LT Hearing Aid:	(HA Make & Model)
Description of RT Hearing Aid:	(HA Make & Model)
A. Co-Pay:	$795 for qty 1 (or $1,490 for qty 2)
B. Upgrade Amount:	$1,795 (Total Cost of 1 HA) – $795 (Copay) = $1,000 (Upgrade Amount)
C. Patient Responsibility:	$795 + $1,000 = $1,795 (A+B=C)

Agreement to Pay:

I understand that I am responsible for the Copay and Upgrade Amount listed above and any additional hearing aid accessories included with my purchase. I understand the total is paid to Amplifon Hearing Health Care at the time of dispensing.

Patient Signature: ______________________________

Date of Signature: ______________________________

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