HearUSA

SERVICE OFFICE
M T W Th F

PURCHASE AGREEMENT (IOWA)

I ("Buyer") hereby purchase from HearUSA ("Seller"), the hearing system and equipment described below, agree to pay the purchase price written, and honor the following terms and conditions of the sale herein specified. The equipment is new, and warranted against defects in material and workmanship for a period of _____ year(s) from the date of purchase. Remakes are warranted for one year only, and ear molds are warranted for remake/refit for 90 days. Ear molds are not covered for loss. In the case of loss or damage during the warranty period, a one-time replacement will be provided for hearing aids and remote controls, subject to a deductible of $_____ per hearing aid.

The purchaser has been advised that any examination or representation made by a licensed hearing aid dispenser in connection with fitting or selection and selling of this hearing aid is not an examination, diagnosis, or prescription by a person licensed to practice medicine in this state and therefore, must not be regarded as medical opinion or advice.

	Manufacturer	**Model**	**Price**
Left			
Right			
Purchase Price			**$**
Professional Services – Testing, Fitting, and Follow-Up			**$ Included**
Ear mold(s)			**$**
Special Features: _____			**$**
Remote Control			**$**
Hearing Test			**$ Included**
Examination of Ear			**$ Included**
Dispensing Services			**$ Included**
In Office Service, Cleaning			**$ Included**
Benefit			**$**
SUBTOTAL:			**$**
OTHER			**$**
NET PURCHASE PRICE PAYABLE:			**$**

BATTERY SIZE: _____

INSURANCE

HearUSA cannot guarantee your benefits or eligibility with your insurance plan. Your insurance plan is a contract between you and your insurance company.

Upon completion of our Patient Information Form and your assignment of benefits, HearUSA will extend the benefit offered by your insurance company and file for reimbursement. HearUSA will handle all of the paperwork for you. All payments for services not covered by your insurance plan are expected at time of visit.

If your insurance company pays only a portion of the bill or denies the claim, an explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of the financial obligation. HearUSA will notify you if this occurs and request payment in full.

_____ _____
Signature of Purchaser **Date**

_____
Signature of Hearing Aid Dispenser **Date**

_____
Name of Hearing Aid Dispenser **HA Dispenser License #**

REFUND & RETURN POLICY

The hearing aid(s) may be returned to the seller within _____ days of the date of actual receipt by you or until completion of fitting by the seller, whichever occurs later. If you return the device, the seller will either adjust or replace the device or promptly refund the amount paid less $75 nonrefundable fee per aid.

DELIVERY RECEIPT

Signature _____Executed/Delivered this _____ day of _____, _____

Full Name *(Please Print)* _____Telephone ( ) _____

_____
Street Address **City** **State** **Zip**

_____ _____ _____
Signature of Hearing Aid Dispenser **Dispenser's License No.** **Date**