



SERVICE OFFICE  
M T W Th F

\_\_\_\_\_to\_\_\_\_\_

**PURCHASE AGREEMENT (KENTUCKY)**

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 at the outset of his relationship with the specialist in hearing instruments that any examination(s) or representation(s) is not an examination, diagnosis, or prescription by a person licensed to practice medicine in this state and therefore shall not be regarded as medical opinion or advice."

	<b>Manufacturer</b>	<b>Model</b>	<b>Serial No</b>	<b>Price</b>
<b>Left</b>				
<b>Right</b>				
<b>Purchase Price</b>				<b>\$</b>
Professional Services – Testing, Fitting, and Follow-Up				<b>\$</b>
Ear mold(s)				<b>\$</b>
Special Features: _____				<b>\$</b>
Remote Control				<b>\$</b>
Hearing Test				<b>\$</b>
Examination of Ear				<b>\$</b>
Dispensing Services				<b>\$</b>
In Office Service, Cleaning				<b>\$</b>
Benefit				<b>\$</b>
<b>SUBTOTAL:</b>				<b>\$</b>
<b>OTHER</b>				<b>\$</b>
<b>NET PURCHASE PRICE PAYABLE:</b>				<b>\$</b>

BATTERY SIZE \_\_\_\_\_

This hearing aid will not restore normal hearing nor will it prevent further hearing loss.

I am over the age of 18 and have been advised by HearUSA that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably one who specializes in diseases of the ear), before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

HearUSA

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**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 Dispenser's License No. Date

**ANY COMPLAINTS CONCERNING THE SALE OR SERVICE OF THIS HEARING INSTRUMENT WHICH ARE NOT CORRECTED BY THE SPECIALIST IN HEARING INSTRUMENTS SHOULD BE DIRECTED TO: KENTUCKY LICENSING BOARD FOR SPECIALISTS IN HEARING INSTRUMENTS COMMONWEALTH OF KENTUCKY, FRANKFORT, KENTUCKY 40601.**

**DELIVERY RECEIPT**

**CLIENT'S RIGHT TO CANCEL WITHIN \_\_\_\_\_ DAYS: "THE CLIENT HAS THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON AT ANYTIME PRIOR TO MIDNIGHT OF THE 90TH CALENDAR DAY AFTER ACTUAL RECEIPT OF THE HEARING INSTRUMENT(S). YOU MAY CANCEL THE PURCHASE BY NOTIFYING THE SELLER THAT YOU DO NOT WANT THE HEARING INSTRUMENT(S) BY MAILING A NOTICE BEFORE \_\_\_\_\_ (date) TO THE SELLER AT THE FOLLOWING ADDRESS: UPON CANCELLATION, THE SELLER MAY KEEP UP TO \$0 PER HEARING AID FOR A TOTAL OF \$0 CANCELLATION CHARGES."**

Signature \_\_\_\_\_ Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Full Name (Please Print) \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Name of Hearing Aid Dispenser Dispenser's License No. Date

\_\_\_\_\_  
Signature of Hearing Aid Dispenser