HearUSA
Hearing Care Network

SERVICE OFFICE
M T W Th F

_____to_____

PURCHASE AGREEMENT (NEW JERSEY)

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 90 days. In the case of loss or damage during the warranty period, a one-time replacement will be provided, subject to a deductible of $_____ per aid.

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

BATTERY SIZE _____

WARRANTY INFORMATION SUPPLIED ☐

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.

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.

ADVISEMENTS

The purchaser has been advised at the outset of his relationship with the hearing aid dispenser that any examination or representation made by a licensed hearing aid dispenser in connection with the practice of fitting and selling of this hearing aid(s), is not an examination, diagnosis or prescription by a person licensed to practice medicine in this State, or by certified audiologists and therefore must not be regarded as medical opinion.

Buyer has been advised that the Buyer's best interests would be served by consulting a licensed physician specializing in diseases of the ear, or any licensed physician, if any of the following conditions exists: visible congenital or traumatic deformity of the ear; history of or active drainage of the ear within the previous ninety days; history of sudden or rapidly progressive hearing loss; acute or chronic dizziness; unilateral hearing loss of sudden onset within the previous ninety days; a significant audiometric air-bone gap; visible evidence of cerumen (earwax) accumulation on, or a foreign body in, the ear canal; and pain or discomfort in the ear.

_____ _____
Signature of Purchaser **Date**

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

DELIVERY RECEIPT

This assistive device is warranted to be specifically fit for the particular needs of you, the buyer. If the device is not specifically fit for your particular needs, it may be returned to the seller within _____ days of the date of actual receipt by you or 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 $0 per instrument. This warranty does not affect the protections and remedies you may have under other laws.

Signature _____Executed this _____ day of _____, 20_____

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

Street Address _____

City, State, & Zip Code _____

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