



**SERVICE OFFICE**  
**M T W Th F**  
 \_\_\_\_\_ to \_\_\_\_\_

**PURCHASE AGREEMENT (NEVADA)**

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, however, are warranted for one year only, and ear molds are warranted for 90 days only. 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.

	<b>Manufacturer</b>	<b>Model</b>	<b>Serial No</b>	<b>Price</b>
<b>Left</b>				
<b>Right</b>				
<b>Purchase Price</b>				\$
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				\$
<b>SUBTOTAL:</b>				\$
<b>OTHER</b>				\$
<b>NET PURCHASE PRICE PAYABLE:</b>				\$

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.

\_\_\_\_\_  
**Purchaser Signature of Hearing Aid Dispenser** \_\_\_\_\_ **Signature of**

\_\_\_\_\_  
**Dispenser's License** \_\_\_\_\_ **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 total amount paid, less \$0 per hearing aid. After this time period, all sales are final. To obtain a refund, please contact your audiologist, \_\_\_\_\_ within the \_\_\_\_ day time period. This warranty does not affect the protections and remedies you have under other laws.**

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

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

**Address** \_\_\_\_\_

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