HearUSA

SERVICE OFFICE
M T W Th F
_____to_____

PURCHASE AGREEMENT (RHODE ISLAND)

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 _____ years from the date of purchase. Remakes and recases, however, 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.

The purchaser has been advised at the outset of his/her relationship with the hearing aid dealer that any examination(s) or representation(s) made by a licensed hearing aid dealer and fitter in connection with the 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 and therefore must not be regarded as medical opinion or advice.

	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.

_____ _____

Signature of Purchaser **Date**

_____ _____ _____

Signature of Hearing Aid Dispenser **Dept. of Health License Number** **Date**

Certificate Number: _____

DELIVERY RECEIPT

Advisements:

1.) Services included: Follow-up visits, in-office re-programming and modifications.
2.) A hearing aid will not restore normal hearing. The purchaser has a _____ day trial period during which time she/he may return the instrument, in the original condition less normal wear, with no further financial obligation. This product is protected by Chapter 945 of Title 6 entitled "Enforcement of Assistive Technology Warranties" which shall be made available by the dispenser, upon request.
3.) If you return the device in satisfactory condition, the seller will either adjust or replace the device or promptly refund the amount paid less with $0 restocking fee.

Signature _____Date of Purchase: _____, 20_____

Purchaser's Full Name *(Please Print)* _____

_____

Purchaser's Street Address City State Zip

Telephone ( ) _____

_____ _____

Name of Hearing Aid Dispenser (Print) Signature of Hearing Aid Dispenser

_____ _____

Department of Health License Number Date