



SERVICE OFFICE
M T W Th F

_____ to _____

PURCHASE AGREEMENT (WEST VIRGINIA)

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 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	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 _____

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

Date

Name of Hearing Aid Dispenser

Hearing Aid Dispenser License No.

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 \$0 per aid.

Signature _____ Executed/Delivered this ___ day of _____, 20____

Full Name (*Please Print*) _____

Street Address City State Zip

Telephone () _____

Signature of Hearing Aid Dispenser Dispenser's License Number Date