ADVANCED NOTICE OF NON-COVERED SERVICES

NOTICE TO PATIENTS:

Please carefully review this notice to make an informed decision about your care. Feel free to ask the Audiologist any questions you may have regarding this notice.

Medicare and insurance do not cover all expenses, including certain care that your health care provider deems necessary.

Speech in Noise Testing (QuickSIN): This test is not covered by insurance.

Purpose of Speech in Noise Testing: Speech understanding in noise cannot be reliably predicted from the pure tone audiogram or other standard audiometric tests alone.

Test Procedure: The test is performed by presenting sentences at the same level while background noise increases. It determines the signal-to-noise ratio (S/N) at which you can understand speech. The test provides a score utilized in counseling for your hearing difficulty and guides the best course of treatment for your individual hearing loss.

Benefits of Testing:

- Specific treatment recommendations.
- Useful for counseling on realistic expectations.
- High face validity: patients report that QuickSIN lists sound like real-world problems.

Cost: The cost for this test is $35.00

Cerumen (Ear Wax) Evaluation and Removal: This service is not covered by insurance.

Purpose of Cerumen Evaluation and Removal: Cerumen impaction is diagnosed by direct visualization (otoscopy). If cerumen accumulation has become symptomatic or prevents needed assessment of the ear canal or tympanic membrane, it is impacted. Cerumen impaction can present with symptoms, including aural fullness, hearing loss, ear pain, itching, tinnitus, and otitis externa.

Test Procedure: Conduct video otoscopy and tympanometry, remove cerumen, if necessary and preform post-removal video otoscopy,

Benefits of Service:

- Remove blockages to the ear canal.
- Improve hearing.
- Ensure accurate hearing test results.

Cost: The cost for this test is $95.00

Options (Please select one):

1. I **WANT** the test listed above. I understand that I will pay for the test today, and my insurance will not be billed. _____ *(initial)*

2. I **DO NOT** want the test listed above. This test will not be performed, and I won't be required to pay for it. _____ *(initial)*

Patient Signature:

_____

Date:

_____