PRICE QUOTE

Patient Name: _____

Make and Model of Recommended Hearing Aid(s): _____

Ear(s): ☐ Binaural ☐ Right Ear ☐ Left Ear

Style: ☐ Behind-the-ear ☐ Receiver-in-Canal ☐ Full-shell, in-the-ear
☐ Canal ☐ Half-Shell ☐ Completely-in-canal
☐ Mini-Canal ☐ Extended Wear ☐ Other: _____

Accessories:

DESCRIPTION	COST

Cost of hearing aid(s): $ _____
Earmold(s), if applicable (non-refundable): $ _____
Cost of accessories, if applicable: $ _____
Less any estimated insurance coverage, if applicable: $ - _____

Total Due: $ _____

TERMS OF QUOTE

1. Payment in full is due on the date of fitting.
2. A _____ business day evaluation and adjustment period is provided with the hearing aid(s). If you lose or damage the aid(s) within this period, the aid(s) cannot be returned.
3. The full purchase price of the hearing aid(s) can be refunded during the trial period, less a restocking fee of $_____ per aid.
4. The cost of the earmold(s) is non-refundable. Earmolds cost $_____ each.
5. All warranties provided are a minimum _____ year loss, damage, and repair warranty.
6. The insurance coverage information provided is an estimate only. We will not know actual insurance coverage amounts until the hearing(s) are billed to insurance and that claim is processed.

_____ _____ _____
Patient Signature Audiologist Signature Date

THIS PRICE QUOTE IS VALID FOR 90 DAYS.