

**Order Number:**
**Patient ID:**
**PO#:**
**Audiologist/Dispenser:**
**Authorization Number:**

Insurance Plan:	Diagnosis Code:	Repair Warranty:	Loss & Damage Warranty:	Free Batteries Qty:
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Qty	L/R	HA Style, Make & Model, Accessories or Services	Serial Number (left)	Serial Number (right)	Date of Service	Price
						\$0.00
						\$0.00
<b>Total:</b>						\$0.00
<b>Est Insurance Benefit:</b>						\$0.00
<b>Adjustments:</b>						\$0.00
<b>Tax:</b>						\$0.00
<b>Amount Due from Patient at the time of delivery:</b>						\$0.00
<b>Type of Payment:</b> (Circle One) *Credit Card *Financing *Check #						

**60-Day Trial Period.** The hearing aids have a 60-day trial period that begins on the date the aids are delivered to you. You may, for any reason, cancel the sale and receive a full refund by returning the original hearing aid(s) during this period, provided that the aids are in the same condition, excluding ordinary wear and tear, as when they were delivered to you.

If the hearing aid must be repaired, remade, or adjusted during the 60-day trial period, the time the device is out of your possession will not count against the trial period. The trial period will resume once you've picked up the device or on the fourth business day following notification that your device is available, whichever is earlier.

If you wish to cancel this sale, you must return the hearing aid(s) to the hearing care professional's office at the address located at the top of this delivery document.

**One Year of Aftercare.** Patient understands and agrees that up to 6 office visits within the first year following purchase are included in the purchase price of their hearing aid. Any additional office visits may be subject to your provider's customary office visit rates.

**One-Time Loss and Damage.** During the 3-year warranty period, Start Hearing will replace a lost or damaged device **one time** for a \$250 **per device** loss-and-damage fee.

**Mutual Acknowledgment of Delivery & Fitting.** Both parties hereby acknowledge that the hearing instruments described above have been delivered and fitted to the Patient. The Provider further hereby confirms that the Provider has fitted the devices to the Patient to the best of the Provider's ability.

**Patient Acknowledgment of Disclosure & Agreement to Terms.** Patient acknowledges (1) that the Provider has provided Patient with this Delivery Document and related documents required by law in the state where Provider is licensed (if any) and agrees (2) that such additional state-specific legal provisions are included by reference in this Delivery Document.

Patient Signature	Date of Delivery/Signed
Provider Signature:	Date of Delivery/Signed

**\*\*Please send this completed form within 24 hours of Delivery/Fitting to: [claims@starhearing.com](mailto:claims@starhearing.com) or by Fax: (952) 995-8884\*\***

**Start Hearing | 6700 Washington Avenue S. Eden Prairie, MN 55344 | For Questions, you may contact us at: (866) 925-1287**