

BUSINESS / CLINIC NAME

ADDRESS 1

ADDRESS 2

PHONE:

FAX:

HEARING INSTRUMENT RECOMMENDATION AND PURCHASE AGREEMENT

WEBSITE:

EMAIL:

Client Name: _____

Client Address: _____

Date of Birth: _____

Home Phone: _____

Other Phone: _____

THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING AIDS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE.

The hearing instrument(s) are: New Used Reconditioned

| EAR | MANUFACTURER | MODEL/STYLE | BATTERY SIZE | AMOUNT |
|---|--------------|-------------|--------------------------------|----------|
| L | | | | \$ _____ |
| R | | | | \$ _____ |
| Options: [describe] | | | | \$ _____ |
| Initial manufacturer warranty: [describe terms] | | | | \$ _____ |
| Additional Warranty: [describe terms] | | | | \$ _____ |
| Loss and Damage Protection: [describe terms] | | | | \$ _____ |
| Service Plan: [describe] | | | | \$ _____ |
| Other: [describe] | | | | \$ _____ |
| Trade-In Allowance: [describe trade-in] | | | | \$ _____ |
| Discount: [describe] | | | | \$ _____ |
| I have had an opportunity to read and review the Minnesota Department of Health Brochure titled "Legal Rights and Consumer Information about Purchasing a Hearing Instrument." Client initial: _____ | | | SUBTOTAL AMOUNT | \$ _____ |
| | | | MN Care Tax (2.0%) | \$ _____ |
| | | | TOTAL PURCHASE PRICE | \$ _____ |
| | | | Deposit Amount | \$ _____ |
| | | | Balance due on delivery | \$ _____ |

MINNESOTA STATE LAW GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER RECEIPT OF THE HEARING AID(S). THIS CANCELLATION MUST BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A CANCELLATION FEE NO MORE THAN \$250.

Trial Period Begin Date: _____

*Trial Period End Date: _____

Cancellation Fee: _____

Refund Amount: _____

The undersigned agrees to the terms, conditions, services, cancellation provisions and price of the hearing instrument(s), accessories and services described above.

Client Signature

Date

Audiologist/Hearing Instrument Dispenser

License/Certification #

Date

*If the hearing instrument must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee period, the running of the 45-calendar day period is suspended one day for each 24-hour period that the hearing aid is not in the buyer's possession.