Meeting Agenda

LEOFF I Disability Board

City Hall
601 4th Avenue E
Olympia, WA 98501

Contact: Carl Watts
360.753.8305

Monday, August 12, 2019 **5:00 PM** **Room 112**

1. CALL TO ORDER

1.A ROLL CALL

2. OTHERS PRESENT

3. APPROVAL OF MINUTES

3.A 19-0710 Approval of April 8, 2019 LEOFF I Disability Board Meeting Minutes

Attachments: Minutes

4. BUSINESS ITEMS

4.A 19-0335 Approval of Case #05-19 Transportation Reimbursement Request

Attachments: 05-19 Reimbursement Request

4.B 19-0711 Approval of Case #06-19 Dental Reimbursement Request

Attachments: Reimbursement Request

4.C 19-0725 Approval of Case #07-19 Hearing Aid Request

Attachments: 07-19

5. REPORTS - None

6. ADJOURNMENT

Accommodations

The City of Olympia is committed to the non-discriminatory treatment of all persons in employment and the delivery of services and resources. If you require accommodation for your attendance at the City Advisory Committee meeting, please contact the Advisory Committee staff liaison (contact number in the upper right corner of the agenda) at least 48 hours in advance of the meeting. For hearing impaired, please contact us by dialing the Washington State Relay Service at 7-1-1 or 1.800.833.6384.

City Hall
601 4th Avenue E.
Olympia, WA 98501
360-753-8244

LEOFF I Disability Board

Approval of April 8, 2019 LEOFF I Disability Board Meeting Minutes

Agenda Date: 8/12/2019
Agenda Item Number: 3.A
File Number: 19-0710

Type: minutes **Version:** 1 **Status:** In Committee

Title
Approval of April 8, 2019 LEOFF I Disability Board Meeting Minutes

Meeting Minutes - Draft

LEOFF I Disability Board

City Hall
601 4th Avenue E
Olympia, WA 98501

Contact: Carl Watts
360.753.8305

Monday, April 8, 2019 **5:00 PM** **Room 112**

1. CALL TO ORDER

1.A ROLL CALL

2. OTHERS PRESENT

3. APPROVAL OF MINUTES

3.A Approval of December 10, 2018 LEOFF 1 Disability Board Meeting Minutes

The minutes were approved.

4. BUSINESS ITEMS

4.A Approval of Case #04-19 Hearing Aid Request

Vice Chair Bateman moved, seconded by Boardmember Gies, to approve payment in the amount of $3,726.27 for hearing aids from Avada. The motion was approved.

4.B Approval of Case #05-19 Transportation Reimbursement Request

The Board delayed decision and will determine whether or not to approve reimbursement at the next LEOFF meeting when the additional medical information is provided.

5. REPORTS

5.A Expense Report for LEOFF 1 Disability Board of November and December 2018

The report was received.

5.B Expense Report for LEOFF 1 Disability Board of January and February 2019

The report was received.

6. ADJOURNMENT

City Hall
601 4th Avenue E.
Olympia, WA 98501
360-753-8244

LEOFF I Disability Board

Approval of Case #05-19 Transportation Reimbursement Request

Agenda Date: 8/12/2019
Agenda Item Number: 4.A
File Number:19-0335

Type: decision **Version:** 2 **Status:** In Committee

Title
Approval of Case #05-19 Transportation Reimbursement Request

Report Issue:
Whether to approve reimbursement of costs for using public transportation for follow-up appointments for a LEOFF member.

Staff Contact:
Debbi Hufana, Benefits Specialist, Human Resources, 360.753.8149

Background:
The member has not submitted any additional medical information since the meeting on April 8, 2019.

The member is requesting reimbursement for transportation related expenses for using public transportation for eye surgery and follow-up appointments after surgery. The member provided a letter from his physician stating the date of the surgery and identified dates for four (4) follow-up appointments and noting additional appointments might be needed in the future. The letter does not indicate the member is unable to drive to these appointments but only the dates of the surgery and the follow-up appointments. The member is seeking reimbursement in the amount of $376.00 for nine (9) trips. The physician's letter includes a date for a follow-up appointment that the member is not requesting reimbursement for. The cost for transportation for the surgery date and the three (3) dates for follow-up appointments identified in the letter from the physician is $168.00. The member is requesting reimbursement for a date one (1) month prior to the surgery date and four (4) dates after the dates stated in the physician's letter. This is not in accordance with LEOFF 1 Disability Board Policies and Procedures, Section III, A which states the services are medically necessary which the physician's letter does not state.

Attachments:
Application for payment
Letter from physician
Payment receipts

Type: decision **Version:** 2 **Status:** In Committee

Reference:
LEOFF 1 Disability Board Policies and Procedures (2018), Section lll, Paragraph A, Medical Services

LEOFF Board Application for Payment of Services Case No: 05-19

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: _____ Active: _____ Retired: yes

Member Telephone: _____ Police: _____ Fire: LEOFF-1

Member Address: _____

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: Elevated pressure in left eye Glaucoma resulting in gradual loss of vision. Tube placed in eye to reduce pressure and various eye drops prescribed to slow process.

Describe the Service/Treatment Requested: 2 Surgeries to relocate tube and remove scar tissue.

RECEIVED
MAR 25 2019
CITY OF OLYMPIA
HUMAN RESOURCES DEPT.

Total Cost of Treatment/Service: $ _____

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ 376.00

reimbursement req. is for transportation costs

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: _____ Date: 3-12-2019

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider
(attach additional pages as needed)

Provider's Name: Aiyin Chen MD Provider's Telephone: 503-494-7667

Clinic/Office Name: Casey Eye Institute Glaucoma Service

Provider's Address: 3303 SW Bond Ave, 11th Floor FAX 503-494-3075

Describe the Patient's Current Condition and State Whether It Is Duty Related: _____

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: _____

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

Provider's Signature: _____ Date: _____

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

CASEY EYE
Institute

South Waterfront

Mail Code CH11P
3303 SW Bond Ave., 11th Floor
Portland, Oregon 97239-4501

Address Service Requested

January 16, 2019

To Whom It May Concern:

had surgery with Dr. Chen on 11/28/18 for glaucoma here in Portland. He needed to be seen for the following postop appointments which were on 11/29, 12/4, 1/4 and 1/15. He might also need further appointments in the future.

Any questions, please call us at 503-494-7667.

Thank-you,

LEOFF 1
Claims Reimbursement Form (Fire)

Name (Last, first)		*Vendor #	22653	Date claim submitted	Mar 12TH 2019
		*Bars #	014-1714-530-22.02		
Address		Primary phone #		Check if new (address, phone or email)	☐
City, State Zip		Cell #			
Email		*HR internal use			

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

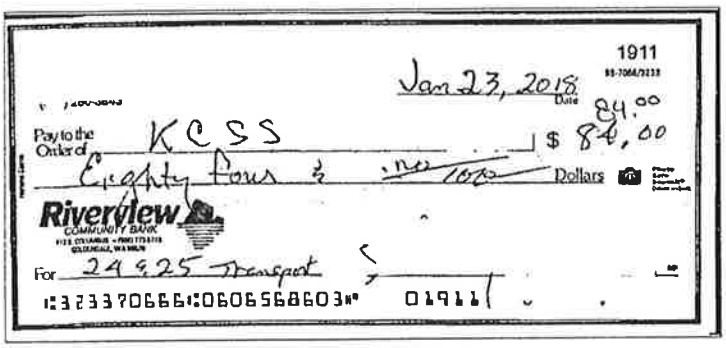
	Date of Service (in date order oldest to newest)	Enter either (prescription, Medical, Dental or Vision)	Description	Qty	Total
1)	Jan 24 & 25 2018	Medical OP & Post OP	Transport From Goldendale to Portland	$42.00 ea	$84.00
2)	Feb 8 & Mar 8TH 2019	" "	Check #1911 a Hached		
			Transport Same 2 trips		
			Check # 1921 a Hached	$42.00	$84.00
3)	Oct 15, 2018	" "	Transport Same 1 trip		
			Check # $2063 a Hached	$40.00	$40.00
4)	Nov 28 & 29TH 2018	Med Op & Post Op	Transport 2 trips	42.00	$84.00
			Check # 2076 a Hached		
5)	Dec 4TH - 2018	Med Post Op	Transport 1-trip	$42.00	$42.00
			Check # 2104		
6)	Jan 15TH, 2019	Med Post op	Transport 1 Trip	$42.00	$42.00
			Doctor Chen letter a Hached		
			Mt Adams Transport administer by Klickitat County Senior Services KCSS		
			Nine Trips Total	9	$378.00

RECEIVED
MAR 14 2019
CITY OF OLYMPIA
HUMAN RESOURCES DEPT

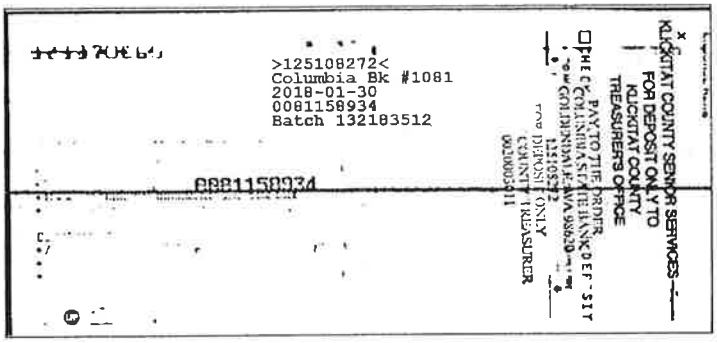
Submit claims for reimbursement via:

- Mail: Attn: HR, City of Olympia, 601 4th Ave. E., Olympia, WA 98501
- Email: humanresources@ci.olympia.wa.us
- Fax: 360-709-2735

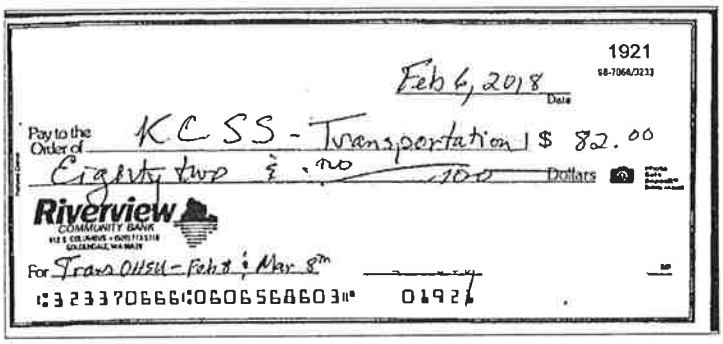
LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website: LEOFF Disability Board Information



1/31/2018 1911 $84.00



1/31/2018 1911 $84.00



1921
98-7064/3233

Feb 6, 2018
Date

Pay to the Order of KCSS - Transportation $ 82.00

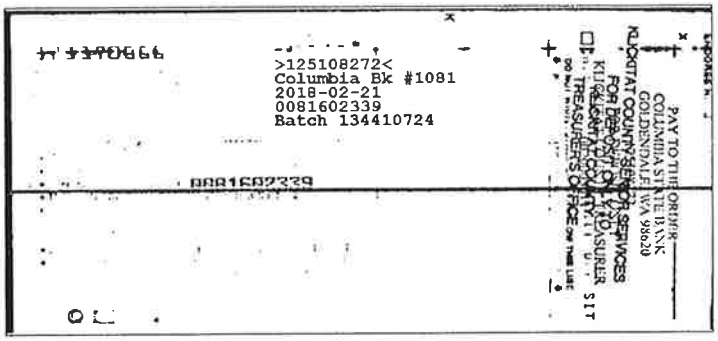
Eighty two & no/100 Dollars

Riverview COMMUNITY BANK

For Trans OHSU - Feb 8 & Mar 8th

⑆323370666⑆0606568603⑈ 01921

2/22/2018 1921 $82.00



>1251082727<
Columbia Bk #1081
2018-02-21
0081602339
Batch 134410724

⑈0081602339

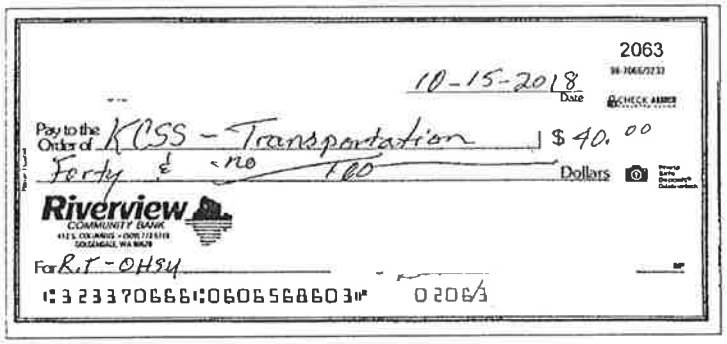
PAY TO THE ORDER OF
COLUMBIA STATE BANK
GOLDENDALE, WA 98620

KLICKITAT COUNTY SENIOR SERVICES

FOR DEPOSIT ONLY TO KLICKITAT COUNTY TREASURER

TREASURER'S OFFICE

2/22/2018 1921 $82.00



2063

10-15-2018
Date

Pay to the Order of KCSS - Transportation $ 40.00

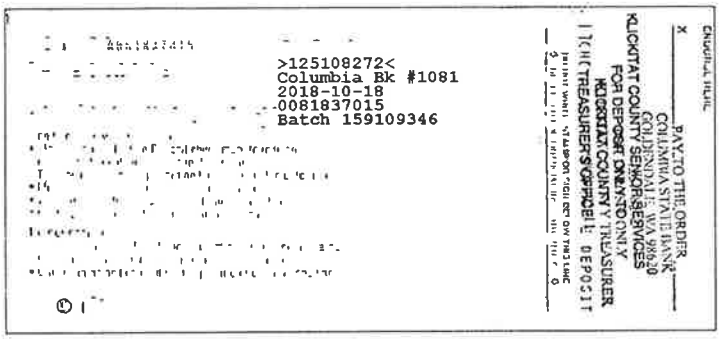
Forty & no 100 Dollars

Riverview COMMUNITY BANK

For R.T - OHSU

⑆323370666⑆0606568603⑈ 02063

10/19/2018 2063 $40.00



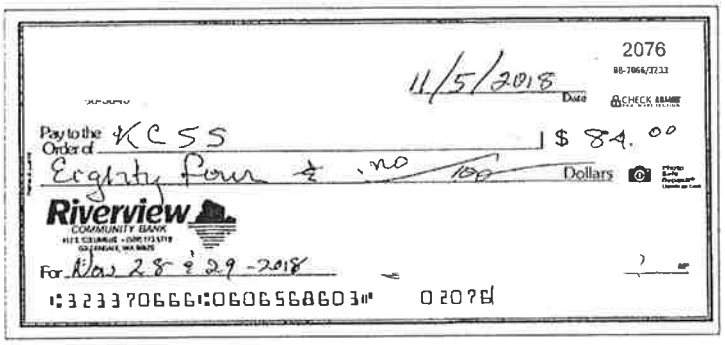
>125108272<
Columbia Bk #1081
2018-10-18
-0081837015
Batch 159109346

ENDORSE HERE

PAY TO THE ORDER
COLUMBIA STATE BANK
COLUMBIA, WA 99320
KLICKITAT COUNTY SENIOR SERVICES
FOR DEPOSIT ONLY TO
KLICKITAT COUNTY TREASURER

KLICKITAT COUNTY TREASURER'S OFFICE DEPOSIT

10/19/2018 2063 $40.00



2076

11/5/2018
Date

Pay to the Order of KCSS $ 84.00

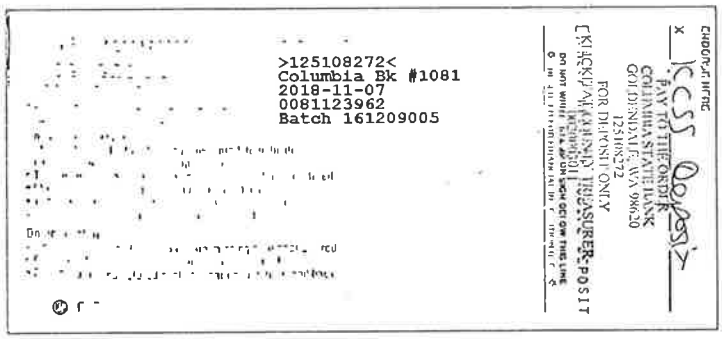
Eighty four + no/100 Dollars

Riverview COMMUNITY BANK

For Nov 28 & 29 -2018

⑆323370666⑆0606568603⑈ 0207

11/8/2018 2076 $84.00



>125108272<
Columbia Bk #1081
2018-11-07
0081123962
Batch 161209005

CHECK/CREDIT

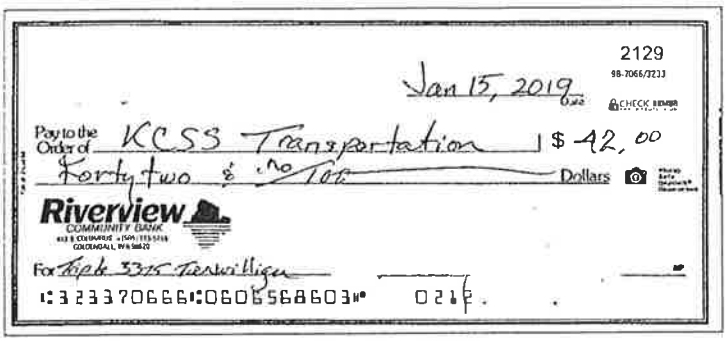
X KCSS Deposit

PAY TO THE ORDER OF
COLUMBIA STATE BANK
GOLDENDALE, WA 98620
125108272
FOR DEPOSIT ONLY

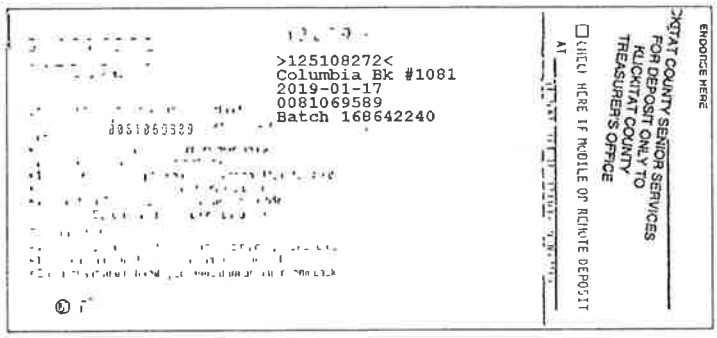
[illegible] TREASURER-POSIT

DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE

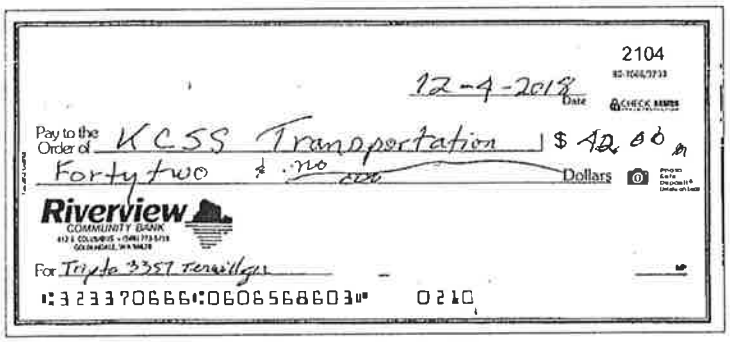
11/8/2018 2076 $84.00



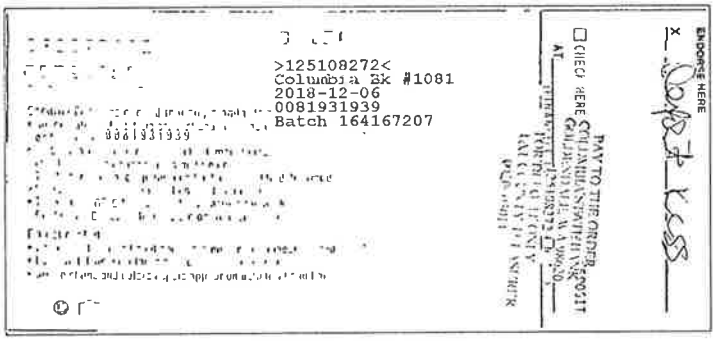
1/18/2019 2129 $42.00



1/18/2019 2129 $42.00



12/7/2018 2104 $42.00



12/7/2018 2104 $42.00

City Hall
601 4th Avenue E.
Olympia, WA 98501
360-753-8244

LEOFF I Disability Board

Approval of Case #06-19 Dental Reimbursement Request

Agenda Date: 8/12/2019
Agenda Item Number: 4.B
File Number: 19-0711

Type: decision **Version:** 1 **Status:** In Committee

Title
Approval of Case #06-19 Dental Reimbursement Request

Report Issue:
Whether to approve payment for dental bills for LEOFF 1 member.

Staff Contact:
Debbi Hufana, HR Analyst, General Government, Human Resources, 360.753.8149

Background:
The Board must decide whether or not to approve the request for dental work in the amount of $7,245.00.

The member is requesting reimbursement for dental work in the amount of $7,245.00 for the services. This is not in accordance with LEOFF 1 Disability Board Policies and Procedures Section III, H which states the member is required to submit the LEOFF Application for Payment of Services before undergoing the procedure.

Attachments:
Reimbursement Request

Reference:
LEOFF Disability Board Policies and Procedures (2018) H, Dental Benefits

LEOFF Application for Payment of Services Case No: 06-19

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

Member Name: _____ Active: _____ Retired: X

Member Telephone: _____ Police: X Fire: _____

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: N/A

Describe the Service/Treatment Requested: REMOVAL OF FOUR BROKEN - DAMAGED LOWER FRONT TEETH. INSTALLATION OF BRIDGE

Total Cost of Treatment/Service: $ 8050.00 7245.00

Amount Paid by Insurance/Medicare: $ N/A

Amount Requested from the Board $ 8050.00 7245.00

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the

Member Signature: _____ Date: 6/26/19

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider

Provider's Name: DR. THINH HO DDS Provider's Telephone: 360-943-4777

Clinic/Office Name: OLYMPIA DENTAL GROUP

Provider's Address: 6050 PACIFIC AVE. SE, LACEY, WA 98503

Describe the Patient's Current Condition and State Whether It Is Duty Related: NOT DUTY RELATED SEE ATTACHED LETTER

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: SEE ATTACHED LETTER

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

4 extractions, bone grafts, implants + implant crowns = $15,780.00

Outcome good, possible implant failure in future.

Provider's Signature: _____ Date: 6/26/2019

Fax completed form to: (360) 709-2735 or

Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

RECEIVED
JUL 01 2019
CITY OF OLYMPIA
HUMAN RESOURCES DEPT.

06-19

LEOFF 1
Claims Reimbursement Form

Name (Last, first)		Vendor #		Date claim submitted	6/28/19
		Bars #			
Address		Primary phone #	see below	Check if new (address, phone or email)	☑
City, State Zip		Cell #			
Email					

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

Date of Service (in date order oldest to newest)	Select either (prescription, Medical, Dental or Vision)	Description	Qty	Total
3-20-19 TO 6-5-19	DENTAL SURGERY	REMOVAL OF BROKEN TEETH INSTALLATION OF BRIDGE		~~8050.00~~
				7245.00
		Total	0	~~8050~~ 7245.00

Submit claims for reimbursement via:

- Mail: Attn: HR, City of Olympia, 601 4th Ave. E., Olympia, WA 98501
- Email: humanresources@ci.olympia.wa.us
- Fax: 360-709-2735

LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website: LEOFF Disability Board Information

Olympia DENTAL GROUP
your smile... our priority

06-19

June 6, 2019

To whom it may concern,

This letter is regarding the treatment for came in for an exam on 3/2/2019. He had bitten down hard on a peach pit and fractured his lower front teeth. Upon review of the x-rays taken, #23-26 had severe bone loss and were non restorable with Cl III mobility. I recommended extracting those teeth & placing a 6 unit bridge from #22-27. This is medically necessary so the patient can eat and chew successfully.

Please don't hesitate to call if you have any questions.

Thank you,

Thinh Ho DDS

6050 Pacific Ave SE • Lacey, WA 98503 • Phone (360) 943-4777 • Fax (360) 753-8974

Olympia Dental Group
Dr. Thinh Ho
6050 Pacific Ave SE
Lacey, WA 98503
(360)943-4777 x

06-19

PATIENT TRANSACTIONS

From 04/22/19 to 05/20/19

Account: (
Patient: (

Date	Patient	ID	Code	D$	Dr	*	T	Surf	Description	Prod.	Charges	Chg Adj	Payment	Pay Adj	Balance
									Previous Balance						0.00
04/22/19		439201	7140	7	7	A	23		Extraction, Erupted Tth or Expo:	200.00					200.00
04/22/19		439201	7140	7	7	A	24		Extraction, Erupted Tth or Expo:	200.00					400.00
04/22/19		439201	7140	7	7	A	25		Extraction, Erupted Tth or Expo:	200.00					600.00
04/22/19		439201	7140	7	7	A	26		Extraction, Erupted Tth or Expo:	200.00					800.00
04/22/19		439201	51	7	7	A			Professional Courtesy Credit			-80.00			720.00
04/22/19		439201	12	7		A			Visa Card Payment - Thank You				720.00		0.00
05/20/19		439201	6740	7	7	A	22		Crown - Porcelain/Ceramic	1100.00					1100.00
05/20/19		439201	6245	7	7	A	23		Pontic - Porcelain/Ceramic	1100.00					2200.00
05/20/19		439201	6245	7	7	A	24		Pontic - Porcelain/Ceramic	1100.00					3300.00
05/20/19		439201	6245	7	7	A	25		Pontic - Porcelain/Ceramic	1100.00					4400.00
05/20/19		439201	6245	7	7	A	26		Pontic - Porcelain/Ceramic	1100.00					5500.00
05/20/19		439201	6740	7	7	A	27		Crown - Porcelain/Ceramic	1100.00					6600.00
05/20/19		439201	2950	7	7	A	22		Core Buildup, Including Any Pir	325.00					6925.00
05/20/19		439201	2950	7	7	A	27		Core Buildup, Including Any Pir	325.00					7250.00
05/20/19		439201	51	7	7	A			Professional Courtesy Credit			-725.00			6525.00
05/20/19		439201	12	7		A			Visa Card Payment - Thank You				6525.00		0.00
									PATIENT TOTALS	**8050.00**	**0.00**	**-805.00**	**7245.00**	**0.00**	**0.00**

Paid 5/20/19 TH

Total Tax on productions and charges: $0.00

****The above totals reflect only those transactions during the dates selected.**

The full account balance is: $0.00.
The full patient balance is: $0.00.

Account BP Balance: $0.00

City Hall
601 4th Avenue E.
Olympia, WA 98501
360-753-8244

LEOFF I Disability Board

Approval of Case #07-19 Hearing Aid Request

Agenda Date: 8/12/2019
Agenda Item Number: 4.C
File Number:19-0725

Type: decision **Version:** 1 **Status:** In Committee

Title
Approval of Case #07-19 Hearing Aid Request

Report Issue:
Whether to approve payment for hearing aids for LEOFF 1 member and if approved, for what amount.

Staff Contact:
Debbi Hufana, H R Analyst, General Government, Human Resources, 360.753.8149

Background:
The board must decide whether or not to approve the request for hearing aids in the amount of $3,800.00 or $2,999.96. He has submitted estimates from:

Costco	Vida 8 ITE	$2,999.96
Miracle Ear Center	Binaural set of 5500	$3,800.00

The member is requesting hearing aids from Miracle Ear Center. In accordance with LEOFF policies and procedures, the member submitted quotes from at least two licensed audiologists. The hearing aids include a three year warranty. The member has not requested hearing aids in the last three years.

Attachments:
Application for payment of services, current hearing test, and estimates are attached.

Reference:
LEOFF Disability Board Policies and Procedures (2018) F. Hearing Aids

LEOFF Board Application for Payment of Services Case No: 07-19

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: _____ Active: _____ Retired: X

Member Telephone: _____ Police: _____ Fire: X

Member Address: _____

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: YES-CONSTANCE EXPOSER TO SIREN AND ENGINE NOISE OF FIRE DEPT EMERGENCY VEHICLES. NO HEARING PROTECTION WAS PROVIDED OR SUGGESTED/ENCOURAGED USE WAS NEVER OFFERED

Describe the Service/Treatment Requested: REPLACE HEARING AIDS. MIRACLE EAR HAS TAKEN CARE OF MY HEARING ISSUES FOR OVER 10 YRS. THEY OFFER A BETTER PRODUCT W/12 PROGRAMS (COST CO 7 PROGRAMS) THE AFTER PURCHASE SERVICE WILL BE AS ALWAYS. I PREFER MIRACLE EAR

Total Cost of Treatment/Service: $ 3800.00

Amount Paid by Insurance/Medicare: $ 0

Amount Requested from the Board $ 3800.00

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: _____ Date: 7-30-19

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider
(attach additional pages as needed)

Provider's Name: LARISA PAASTA Provider's Telephone: 360-491-4460

Clinic/Office Name: PANORA MA

Provider's Address: 1450 NORTHWEST LANE LACEY, WA

Describe the Patient's Current Condition and State Whether It Is Duty Related:
bilateral hearing loss duty related.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
Patient need hearing aids.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
no alternative treatment

Provider's Signature: _____ Date: 07-30-19

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

Revised 12/27/07

Miracle-Ear Center
1110 College St SE Suite A
Lacey, WA 98503

July 2, 2019

Re: Phillip S. Swor

Please accept my proposal to fit with our top of the line hearing aids, which are a binaural set of 5500 in the canal hearing aids. These hearing aids include a 3 year warranty, cleaning, adjustments and hearing evaluations for the life of the hearing aids (approx. 5 years). This can be done for the prior agreed discounted amount of $3800. If you have any further questions please call our office at (360)923-0464.

Thank You,

Doreen Keator

Hearing Instrument Specialist

WA LIC#638

Telephone: 360 923-0464

Fax: 360 923-2438

Miracle-Ear Center
1110 College St SE Suite A
Lacey, WA 98503

July 2nd 2019

Re:

Subject: LEOFF 1 Hearing Aid Claim

Dear Mr. Watts,

I am requesting that you take my pre approval into consideration for hearing aid benefits. He has been a patient of mine since 12/28/2009. Our hearing aids meet the requirements of a 3 year warranty. A life time after care program for cleaning, reprogramming and testing at no additional charge. Miracle Ear has been in business for over 70 years; our location is convenient for to get his hearing aids, follow ups and service. I have been licensed as hearing aid fitter and dispenser for over 28 years. I have been National Board Certified in Hearing Instrument Sciences for over 20 years. Any questions please call (360)923-0464.

Thank You,

Doreen Keator

Board Certified Hearing Instrument Sciences

WA LIC#638

Telephone: 360 923-0464

Fax: 360 923-2438

COSTCO
HEARING AID CENTER

1470 Marvin Rd NE
Lacey, WA, 98516, USA
(360) 412-3504

5212416

Sun - 10:00am to 6:00pm, Mon,Tue,Wed,Thu,Fri - 10:00am to 8:00pm, Sat - 9:30am to 6:00pm

PRINT NAME OF USER _____ MEMBERSHIP NO. _____

ADDRESS _____

_____ TELEPHONE NO. _____

PRINT NAME OF BUYER (INDICATE IF BUYER IS THE SAME AS USER) _____ MEMBERSHIP NO. _____

ADDRESS _____

_____ TELEPHONE NO. _____

Item Description	Item #	Model/Description	Manufacturer Warranty	Unit Price	Total Amount
Right Hearing Aid	1277813	Vida 8 ITE Right Loss & Damage Warranty Battery Size 13	36 mths 24 mths	1,349.99	1,349.99
Left Hearing Aid	1277813	Vida 8 ITE Left Loss & Damage Warranty Battery Size 13	36 mths 24 mths	1,349.99	1,349.99
Accessory	799863	Resound TV Streamer 2	12 mths	259.99	259.99
Accessory	892697	Perfect Drylux	36 mths	39.99	39.99

☐ Check ☐ Cash ☐ Credit Card ☐ Debit

Tax (if applicable) _____
Total _____ 2999.96

Manufacturer warranty periods are noted above:

180-DAY TRIAL PERIOD: During the 180-day trial period following the Dispensing Date, you may return the hearing aid, component, ear mold, and accessories for any reason to receive a full refund provided you return the item to the Costco Hearing Aid Center in the same condition as when purchased, ordinary wear and tear excluded. The 180-day trial period shall commence from the date the hearing aid is originally delivered to you or the date this purchase agreement is delivered to you, whichever is later. No cancellation fee will be assessed by the Costco Hearing Aid Center.
LAST DAY TO RETURN ITEMS FOR FULL REFUND: _____

MANUFACTURER WARRANTY POLICY: Beginning on the Dispensing Date, as identified below, the hearing aid, components, ear mold and accessories you purchased are warranted by the manufacturer to be free from all defects in materials and workmanship, and the manufacturer agrees to make all necessary repairs or, at the manufacturer's option, provide a replacement without charge to the buyer during the warranty periods noted above.

Buyer's Initials: _____

[Rev. 11/10/17]

OTOsuite

3894891

Age:

Date of birth

Report Date: 6/28/2019

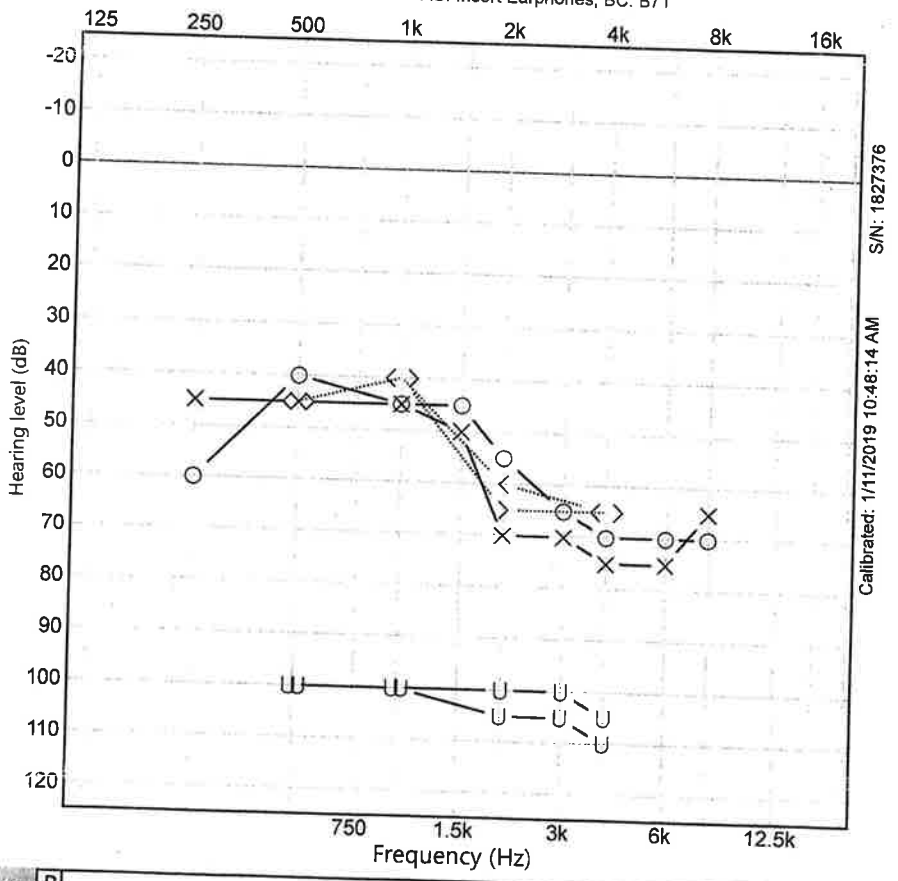
Tester: scl

COSTCO HEARING AID CENTER

Report Comments:

AUDIOMETRY 6/28/2019

AC: Insert Earphones, BC: B71



AC	R	
	L	
BC	R	
	L	

Reliability

PTA (dB HL) / AI (%)

	AC	BC	AI
Right	47	48	9
Left	53	50	5

Legend

L		R		Masked	
X		O	AC	□	△
>	^	<	BC	⊐	⊏
S	S	S	SF	⁒	∅
M		M	MCL		
U		U	UCL		
↘	↓	↙	NR		

PTA AC: 500, 1k, 2k

BC: 500, 1k, 2k

Aud Method:

Speech	SDT		SRT		WRS / SRS 1				WRS / SRS 2				MCL	UCL
	dB HL	[m]	dB HL	[m]	%	dB HL	[m]	S/N	%	dB HL	[m]	S/N	dB HL	dB HL
Right			55		57.0	90							90	100
Left			60		71.0	90							90	100
Bin					92.0	85								
Note	[1] NU-6 1A - Ordered by Difficulty								[2] NU-6 2A - Ordered by Difficulty					
Aided														
Note	[1]								[2]					

Signed by: Dmudel

Tone/Speech - Tabular (1.0)

60853559