Fine Hearing Care
Come home for your hearing healthcare

Hearing Solutions

Oklahoma Hearing Solutions
Patient Intake

Welcome to Oklahoma Hearing Solutions, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on this form.

How did you hear about us? _____

PATIENT INFORMATION:

Patient's Name: _____
FIRST MIDDLE LAST

Mailing Address: _____
STREET CITY STATE ZIP

Preferred Name: _____ Social Security Number: _____

Date of Birth: _____ Age_____ Gender: ☐ Male ☐ Female Marital Status:_____

Phone Number: _____ Cell: _____ Work:_____

Email Address:_____

I do not have an email address: _____ May we contact you via email? Yes _____ No _____

Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

Employment Status: _____ Employer:_____

Patient's Primary Care Physician: _____

Address: _____ Date of Last Visit: _____

Phone Number: _____ Fax Number: _____

Patient's Previous Audiologst:_____

IN CASE OF EMERGENCY:

Listed below are the name(s) & phone number(s) of individuals who I am giving permission to receive information from this office which pertain to me, my health status, my account at this office, or pending health or financial responsibilities as related to this office. This office has permission to leave a phone message regarding appointment times, request for return phone calls, or the status of any hearing devices that have been ordered.

Name_____ Phone _____ Relationship_____

Name_____ Phone _____ Relationship_____

Name_____ Phone _____ Relationship_____

GENERAL HEALTH INFORMATION

Do you have pain/discomfort in your ear? ☐ Right ☐ Left ☐ N/A
Do you have any drainage in your ear? ☐ Right ☐ Left ☐ N/A
Do you have a history of ear infections? ☐ Right ☐ Left ☐ N/A
Do have ringing or other noises in your ear? ☐ Right ☐ Left ☐ N/A **constant** or **intermittent**?
Do you have dizziness or vertigo? ☐ Yes ☐ No
Have you ever had ear surgery? ☐ Right ☐ Left ☐ N/A

Please describe_____

Have you seen your physician regarding any of the above?_____

Does anyone in the household smoke? ☐ Yes ☐ No

Please check if you have experienced any of the following: (Check all that apply)

- ☐ Heart disease
- ☐ Stroke/TIA
- ☐ Liver Issues
- ☐ Mumps
- ☐ Asthma
- ☐ Radiation/Chemotherapy
- ☐ Chronic Sinus Infections
- ☐ Loss of consciousness
- ☐ Depression
- ☐ Diabetes
- ☐ Meningitis
- ☐ Cancer:_____
- ☐ Measles
- ☐ Breathing/respiratory difficulties
- ☐ Long Term IV antibiotics
- ☐ HIV/AIDS
- ☐ Thyroid Disease
- ☐ High blood pressure
- ☐ Kidney or Renal Issues
- ☐ Environmental Allergies
- ☐ Scarlet Fever
- ☐ Visual Problems
- ☐ Mental Illness
- ☐ Tuberculosis
- ☐ Exposure to Chemicals/Solvents
- ☐ Other_____

PLEASE LIST YOUR CURRENT MEDICATIONS (INCLUDING PRESCRIPTION, OVER THE COUNTER, HERBALS, VITAMINS/DIETARY SUPPLEMENTS):

MEDICATION:	DOSAGE:	FREQUENCY:	ROUTE OF ADMINISTRATION:
1.			
2.			
3.			
4.			

**IF NEEDED PLEASE LIST ADDITIONAL MEDICATIONS ON A SEPARATE PIECE OF PAPER.

CURRENT HEARING INFORMATION:

What brings you in today? _____
Do you think you have a hearing loss? Yes_____No_____ Right Ear____ Left Ear____ Both____
Is there a family history of hearing loss? Yes_____No_____ If yes, who: _____
Have you had noise exposure? Yes_____No_____
If yes, from work/military/hobbies, etc., please specify _____
Have you had your hearing tested before? Yes_____No_____ When_____ Results_____
Do you currently use a hearing aid? Yes_____No_____ If yes, how long? _____
Age of current hearing aid(s): _____ Type?_____
Are you satisfied with it/them? Yes____No____
Is there anything else you want our Audiologist to know before seeing you? _____
_____

INSURANCE INFORMATION: Please present insurance card to be copied for your file.

Disclaimer: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you will be required to pay for your portion of the hearing aids at time of fitting including deductibles, co-insurance, any upgrade fees, and taxes. Upon receipt of payment from your insurance company, we will reimburse you if insurance pays more than we anticipated. It is your responsibility to notify us if your insurance changes. Insurance companies have a filing deadline, so failure to provide us with the correct insurance information at the time of service may result in you being responsible for the entire bill. In the event that your insurance company denies payment for services rendered, you will personally and fully be responsible for those charges. PLEASE INITIAL: _____

PRIMARY INSURANCE

Insurance Company: _____ Specialist Copay: _____

Name of Insured: _____ Relationship to Patient: _____

Member ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Insurance Company: _____ Specialist Copay: _____

Name of Insured: _____ Relationship to Patient: _____

Member ID Number: _____ Group Number: _____

I hereby authorize Oklahoma Hearing Solutions, LLC to furnish information to the insurance carriers concerning my diagnosis and/or treatment and hereby to assign the provider all payments for medical services rendered to my dependents or myself. I understand that I am ultimately responsible for any amount not covered by insurance.

Signature: _____ Date: _____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔

Send a copy to my physician _____ (initial)

DO NOT send a copy to my physician _____ (initial)

Please list below any additional health care providers, rehab nurses, case managers, attorneys, schools, etc. that you wish for us to share audiological results with:

Recipient's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Recipient's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Privacy Practice Notice: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:

SIGNATURE_____ DATE_____

OFFICE FINANCIAL POLICY:

We appreciate you trusting us to provide hearing healthcare to you and/or your family. Because we value our relationship with you and believe the best relationships are based on understanding, we offer these clarifications of methods of payment for services. We are dedicated to providing the best care for our patients. Therefore, please note the following:

We offer the convenience of keeping your credit card on file. Your credit card information may be used to pay for your co-pay, and/or additional payments due once your insurance company has processed your claim. Your credit card may also be used to process refunds due to you in the event of an overpayment. Any charges incurred that are not covered by insurance per your explanation of benefits (EOB) may be charged to your credit card. If your insurance company pays us in full, then your credit card will not be used. Please see below (Credit Card on File Authorization) for more information.

Credit Card on File Authorization: I would like to place my credit card on file to be charged by Oklahoma Hearing Solutions, LLC for any patient responsibility charges. This includes any charges that may be due after they file a claim with my insurance company. After they receive my processed claim from insurance, they will send me a notification of my balance. After 30 days, if other arrangements have not been made, my card on file will then be billed any balance left by my insurance carrier. I, _____, authorize Oklahoma Hearing Solutions, LLC to run my credit card for the purpose(s) stated above.

Name on Card: _____

Authorizing Signature: _____

Payment Methods: I understand, we accept Visa, MasterCard, and Discover Card, check or cash. We also accept CareCredit allowing you to setup payment arrangements as needed.

Initial _____

Patient Financial Responsibility: I understand, payment in full, as service is rendered is required. This includes copays, deductibles, coinsurance, and uncovered service or product.

Initial _____

Returned Check Fee: I undersand, there is a $35 service charge for any returned check. After receiving one returned check for insufficient funds, you will no longer be able to pay for services by check. Any balances due will need to be paid by cash, credit/debit card, money order, or CareCredit.

Initial _____

Minors: I understand, minors under the age of 18 must be accompanied by a parent or guardian for treatment. The accompanying adult is responsible for payment on date of service. This includes divorce situations.

Initial _____

Insurance Claims: I understand, as the patient/parent/guardian, I am responsible for the cost of services provided regardless of insurance coverage. As a courtesy, we will file medical claims to your insurance company. Therefore, it is necessary to present ALL current insurance cards at the time of your appointment. We must be notified immediately of any changes. Please ensure all information is accurate and current. As the insured, your coverage is based on the contract between you and your insurance carrier. You must contact your health plan if you have not received notice of payments within 30-45 days of your service. Remember, it is ultimately your responsibility to verify coverage for your particular insurance plan. If the insurance company denies the claim, you are responsible for the balance. Please be aware that some services provided may be non-covered services and not considered reasonable or necessary by your insurance plan. We make every attempt to communicate out of pocket charges to you prior to, and/or during your visit; however your insurance company has the ability to refuse payment at any time, without prior notification to the provider or patient. These charges ultimately become the responsibility of the patient.

Initial _____

Referrals: I understand, many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient/parent/legal guardian to obtain any referral, and updates, required by their insurance plan. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.

Initial _____

No Show/Late Cancellation: I understand, in order for us to provide the best service to our patients, it is important that every patient attend their appointments as scheduled. If you miss a scheduled appointment, we aren't able to track your health progress and you have taken time away from another patient who needed to be seen. It will be considered a missed appointment if you do not give 24 hours advance notice that you will not be coming. If you call to reschedule less than 24 hours before your appointment, it will be considered a missed appointment. There will be a $25-$100 charge for a missed appointment depending on the type of appointment. Three missed appointments will result in dismissal from our office. It is important that you provide current contact information so that we may remind you of your appointments. We use phone, email, and text reminders.

Initial _____

Patient Attendance Policy: We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you to reschedule to another date/time.

Initial _____

Outstanding Balances: If you have a previous balance, you will be required to pay your past due balance plus the charges for your current visit prior to services being rendered.

Initial _____

Collections: Should your account be turned over to collections, you will be responsible for all costs of collection, to include the percentage paid to the collection fee, without limitation, attorney's fee, and court costs. This would also result in dismissal from our office.

Initial _____

Please let us know if you have any questions about any of our office policies. We look forward to years of close association with you as we work together to maintain your hearing health.

I have read and understand the Office Financial Policy and agree to abide by its contents.

Signature of Responsible Party: _____

Print Name of Responsible Party: _____

Relationship to Patient: _____ Date: _____

Oklahoma Hearing Solutions

2405 S. Bryant, Suite 100 Edmond, OK 73013 Phone: 405.340.9191 Fax 405.340.9185

408 S. Mustang Road, Suite B Yukon, OK 73099 Phone: 405.265.1133 Fax 405.265.1144