Fine Hearing Care
Come home for your hearing healthcare

Hearing Solutions

Oklahoma Hearing Solutions
Pediatric 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? _____

PEDIATRIC 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 Phone Number: _____

Child lives with: ☐ Father ☐ Mother ☐ Both Other: _____

Who has legal custody of this child? _____

Patient's Primary Care Physician: _____

Address: _____ Date of Last Visit: _____

Phone Number: _____ Fax Number: _____

PARENT/GUARDIAN INFORMATION:

Name of Parent/Guardian: _____ D.O.B: _____

Home Phone: _____ Cell: _____ Work: _____

Address [if different from above]: _____

Email Address: _____ Social Security Number: _____

Employer: _____ Position: _____

Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

Name of Additional Parent/Guardian: _____ D.O.B: _____

Home Phone: _____ Cell: _____ Work: _____

Address [if different from previous]: _____

Email Address: _____ Social Security Number: _____

Employer: _____ Position: _____

Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

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 my child, their 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_____

REASON FOR THIS VISIT: [Check All That Apply]

- ☐ Parent/Guardian Concern
- ☐ Primary Care Physician Concern
- ☐ Failed Screening at School
- ☐ Failed physician screening
- ☐ Part of a Diagnostic Process
- ☐ Other_____

GENERAL HEALTH INFORMATION

Describe your child's general health: _____

What significant illnesses has your child had? _____

_____

What medications does your child currently take? _____

_____

Are there concerns about your child's speech? ☐ Yes ☐ No _____

_____

Does your child receive special services? [speech, ot, pt, etc.] ☐ Yes ☐ No _____

Does your child have vision problems? ☐ Yes ☐ No _____

CURRENT HEARING INFORMATION: [If you answer yes on any of the following please explain.]

Has your child ever had a hearing test? ☐ Yes ☐ No When? _____

Does your child experience hearing loss? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both

If he/she does experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the child's hearing loss? _____

What do you think is the cause of the hearing loss? _____

Does your child wear hearing aids? ☐ Yes ☐ No If so, for how long? _____

Have a history of ear infections or ear aches? ☐ Yes ☐ No Last Known Infection:_____

Did your child have a hearing screening at birth? ☐ Yes ☐ No Results? _____

Has your child ever been seen by an ENT or Audiologist? ☐ Yes ☐ No Who? _____

Has your child ever had tubes placed in his/her ears? ☐ Yes ☐ No When? _____

Is there anything else that you want our audiologist to know before seeing your child? _____

_____

_____

BACKGROUND INFORMATION

Are there any family members with hearing loss? ☐ Yes ☐ No _____

_____

Family members with speech problems? ☐ Yes ☐ No _____

_____

Family members with learning disabilities? ☐ Yes ☐ No _____

_____

Please list names of all siblings along with their ages:

NAME: _____ AGE:_____

NAME: _____ AGE:_____

NAME: _____ AGE:_____

NAME: _____ AGE:_____

**If needed please list additional siblings on a separate piece of paper.

Did your child experience any of the following at birth? [check all that apply]

☐ Jaundice ☐ Breathing/respiratory difficulties ☐ Premature birth
☐ Low birth weight ☐ Infection of baby or mother ☐ Blue color
☐ Cesarean birth ☐ Sucking/swallowing difficulties ☐ Induced labor
☐ Breech birth ☐ Low APGAR score
☐ Other_____

Does anyone in the household smoke? ☐ Yes ☐ No

Did the mother use tobacco or smoke during pregnancy? ☐ Yes ☐ No

If yes, number of cigarettes/uses per day? _____

Did the mother drink alcoholic beverages during pregnancy? ☐ Yes ☐ No

If yes, what was the frequency and amount consumed? _____

Did the mother use recreational drugs during pregnancy? ☐ Yes ☐ No

If yes, what drugs and how often? _____

Did the mother take any other medications during pregnancy [other than vitamins]? ☐ Yes ☐ No

If yes, what drugs and for what condition[s]? _____

PLEASE READ AND SIGN/INITIAL:

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

Send a copy to my child's physician _____ (initial)

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

Please list below any additional health care providers, rehab nurses, case managers, attorneys, schools, etc. that you wish for us to share your child's 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_____

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: _____

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
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