Fine Hearing Care
Come home for your hearing healthcare

Oklahoma Hearing Solutions

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
- ▫ Other____
- ▫ 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

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.

PRIMARY INSURANCE

Insurance Company: ____ Specialist Copay: ________________

Name of Insured: ________________________________ Relationship to Patient: ___________________________

Member ID Number: ______________________________________ Group Number: _________________________

Insured Date of Birth: ___________________________

SECONDARY INSURANCE

Insurance Company: ____ Insured Date of Birth: ________________

Name of Insured: ________________________________ Relationship to Patient: ____________________________

Member ID Number: ______________________________________ Group Number: _________________________

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.

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: __________________________________

<u>Privacy Practice Notice</u>: 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:

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. If you would like to keep a Credit Card on file with us for future payments or purchases, please let a member of our staff know and we will do so for your convenience.

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

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.

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.

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.

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.

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.

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.

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.

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.

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

Advanced Beneficiary Notice (ABN)

We expect that Medicare and some takeover plans will not pay for the item(s) or service(s) that are described below. Insurance does not pay for all your health care costs. They will only pay for covered items or services when certain rules are met. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, for this specialty, they **will likely not pay for:**

Items or Services:

Office Visits; Cerumen (Wax) Removal; Hearing Aids; Hearing Aid Cleanings; Hearing Aid Repairs; Hearing Aid Fittings; Earmolds; Ear Protection; Annual Hearing Tests without Primary Care Physician Referral

Because:

Medicare/some HMOs and takeover plans will not reimburse an Audiologist for the above items or services, even though they are in our scope of practice.

The purpose of this form is to help make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.

Please choose **ONE** of the following options. Sign and Date your choice.

Option 1: I want the services listed above, but do not bill insurance. I may be asked to pay now as I am the responsible party for payment. *I cannot appeal if insurance is not billed.*

Signature: ____ Date: ________________

Option 2: I want the services listed above. I may be asked to pay now, but I also want insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice or Explanation of Benefits. I understand that if insurance doesn't pay, I am responsible for payment, but I can appeal by following the directions on the MSN/EOB. If insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

Signature: ____ Date: ________________

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