Information You Should Know

Insurance
We are contracted with several insurance plans. It is necessary for you to know that one or more services may not be covered by your insurance, Sooner Start, or Medicaid. You may be asked to pay for any non-covered services at the time of your appointment. This will include any co-pays, deductibles, and co-insurance if such an amount can be determined. If we are out of network with your insurance, we will be happy to file a claim, but you are responsible for the full amount. Please contact your insurance company if you have questions regarding your benefits or provider participation. Please remember it is the patient’s responsibility to keep us informed of all insurance changes. A statement for the remaining balance will be sent and payment is due upon receipt. Please see the back of this page for a list of contracted insurance companies.

If your insurance plan is an HMO and/or requires a written authorization or referral, please contact your primary care physician to obtain the authorization before the appointment. Authorizations may be faxed to 405-548-4350. Please call before your appointment to see if it has been received.

The Hearts for Hearing Foundation was founded to help families of newly diagnosed children, birth to age five, with the cost of their initial pair of hearing aids and associated charges. Families may submit an application to the Foundation for assistance with the child’s needs. Please ask any of our staff members for more information.

Appointments
Hearts for Hearing provides specialized care and we have patients on waiting lists to be seen. We understand that emergencies arise on occasion, however we ask you to please provide at least 24 hours’ notice if you need to cancel an appointment. Please understand that you may be charged $25 if you do not show for a scheduled appointment. Patients who do not show for their appointment will be rescheduled to the first available appointment.

Please arrive 15 minutes early for new appointments to insure you are ready for the provider at your appointment time. It will be necessary for all patient to update their demographics and insurance annually; no exceptions.

Hearing Supplies
Hearing aids and supplies are considered durable medical equipment (DME). The coverage of DME varies with individual insurance plans. If it is determined that the patient is need of a hearing aid, Hearts for Hearing will help to determine the coverage. You will be required to pay your portion at the time the patient is fit with the technology. Hearts for Hearing is only required to fit the patient with hearing aids covered by your insurance plan. Should you choose to upgrade to a more expensive hearing aid you will be responsible for the additional cost. Please understand that any quote by your insurance is not a guarantee of payment.

There is a separate charge of the earmold(s). This service is considered a “supply” and is rarely covered by insurance. An earmold is $110+tax per side.

Locations
We now have five clinics! Please be sure to confirm the address of your upcoming appointment.

11500 N. Portland Ave
OKC, OK 73120
(Pediatric & Adult)

5350 E. 31st Street
Tulsa, OK 74135
*Inside Legacy Plaza
(Pediatric & Adult)

501 E. MacArthur Street
Shawnee, OK 74804
*Inside Robinson Eye Inst.
(Adult Only)

501 E. 31st Street
OKC, OK 73120
*Inside Variety Care
(Pediatric & Adult)

721 W. Britton Road
OKC, OK 73120
*Inside Variety Care
(Adult Only)

NEW LOCATION 3/26/19

500 SW 44th Street
OKC, OK 73109
*Inside Variety Care
(Adult Only)
Hearts for Hearing 2019 Insurance List

Participation is limited to the following plans:

- Aetna- All plans including Integris Employees (some plans need AUTH)
- BCBS- All plans (Bluelincs and HMOs need AUTH)
- Community Care- except for St Johns and St. Francis (need AUTH)
- Coventry
- First Health
- Generations and Global Healthcare (need AUTH)
- Healthcare Highways
- Healthchoice (Earmolds and SLE need auth)
- Indian Health (PATIENT NEEDS TO GET NEW AUTH EVERY VISIT)
- Medicare (Includes Humana, AARP, Secure Horizons Medicare Replacement)
- Oklahoma Health Network/OHN
- OSMA
- Preferred Community Choice
- SoonerCare (SLE, therapy, and equipment needs AUTH)
- SoonerStart
- Stillwater Collaborative Care Program
- Tricare- All Plans (Prime needs AUTH)
- Oklahoma Dept. of Vocational Rehab (DRS) (NEEDS NEW AUTH EVERY VISIT)
- WebTPA- Including Integris HealthPartners
- Kempton Group/First Health

Non-Participating
We are happy to see you if you have one of the following insurance plans. Please be aware it may change your benefits if you choose an out-of-network physician. The list below consists of the most common insurance plans and is not a complete list of all out-of-network plans.

- Cigna
- Community Care St. John HMO
- Community Care St. Francis HMO
- GEHA
- Humana (Jace & Joanna are the only in-network providers)
- Multiplan/PHCS
- United Healthcare and All Subsidiaries (HMOS’s need auth)
  (Assurant, UMR, PacifiCare, Golden Rule, etc.)
- Medishare

Revised 2/11/2019
Patient Name: ___________________________ Social Security #: ___________________________

Date of Birth: ___________ Sex: _______ Home Phone: ___________ Cell: _______________________

Address: ___________________________________ City ___________________ ST _____ Zip __________

County: ___________________ Email: ________________________________

Race: ______________ Ethnicity (circle one): Hispanic Non-Hispanic Preferred Language: ____________

Primary Care Physician: ___________________________ Phone Number: __________________________

Referring Physician: ___________________________ Phone Number: __________________________

Emergency Contact: ___________________________ Phone Number: __________________________ Relationship: ____________

**Parent(s) or Legal Guardian (children only)**

Parent: ______________ Date of Birth: ___________ Social Security Number: __________________________

Parent’s Education (circle one): Some High School High School Some College College Advanced Degree

Parent: ______________ Date of Birth: ___________ Social Security Number: __________________________

Parent’s Education (circle one): Some High School High School Some College College Advanced Degree

**Insurance Company Name:** ___________________________ Address: ___________________________

Policy Number: ___________________________ Group Number: ___________ Effective Date: _______ Co-Pay: _______

Subscriber’s Name: ___________________________ Date of Birth: ___________ Social Security: ____________

Relationship: ___________________________ Insurance Phone: ___________________________

**Secondary Insurance Company Name:** ___________________________ Address: ___________________________

Policy Number: ___________________________ Group: ___________________ Effective Date: __________

Subscriber’s Name: ___________________________ Date of Birth: ___________ Social Security: ____________

Relationship: ___________________________ Insurance Phone: ___________________________

I authorize my insurance benefits to be paid directly to Hearts for Hearing. I understand that I am financially responsible for any balance. I authorize Hearts for Hearing or my insurance company to release any information needed to process my claims. I give permission to you and any agent of Hearts for Hearing to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. I am aware of this office’s Notice of Privacy practices and fully understand my rights as a patient.

Signature __________________________________ Date __________

☐ check here if you do not wish to receive occasional mailings from Hearts for Hearing (Newsletters, events, etc)
CASE HISTORY (PEDIATRIC)

Date: ____________________  Patient Name: ____________________  Date of Birth: ____________________

What is your primary concern regarding your child’s hearing and/or speech and language development?
__________________________________________________________________________________________________________________________________________________

Do you think your child has hearing loss?  ○ Yes  ○ No
If yes, when did it begin and what caused it?  _______________________________________________________________________________________

Please mark “Yes” or “No” and your provider will obtain more detailed information during the appointment:

HEARING HISTORY

○ Yes  ○ No  Did your child pass his/her newborn hearing screening?
○ Yes  ○ No  Has your child had any additional hearing tests before?
  If yes, please describe the results:  _______________________________________________________________________________________
○ Yes  ○ No  Is there a family history of hearing loss in childhood or early adulthood?
  If yes, please describe:  _______________________________________________________________________________________
○ Yes  ○ No  Does your child currently use a hearing aid or cochlear implant?  ○ Right Ear  ○ Left Ear  ○ Both Ears

PREGNANCY & BIRTH HISTORY

At what hospital was your child born?  _______________________________________________________________________________________
Length of pregnancy:  ________ weeks  Baby’s birthweight:  ________ lbs.  ________ oz.

○ Yes  ○ No  Did your child spend any time in the NICU after birth?
  If yes, for how long and why?  _______________________________________________________________________________________
○ Yes  ○ No  Did mother use alcohol during the pregnancy?
○ Yes  ○ No  Did mother use tobacco during the pregnancy?
○ Yes  ○ No  Did mother use drugs during the pregnancy?
○ Yes  ○ No  Was mother Rh incompatible during the pregnancy?
○ Yes  ○ No  Did mother have any major illness during the pregnancy?
○ Yes  ○ No  Was there any infection or virus affecting mother or baby during the pregnancy?

Please check all of the following that occurred at the time of or immediately following birth:

○ Breathing/respiratory difficulties  ○ Positive for CMV  ○ Yellow/Jaundice  ○ Cleft lip/Cleft palate
○ Medications given to infant  ○ Low APGAR score  ○ Blue color  ○ Birth defect
○ Other  _______________________________________________________________________________________

MEDICAL HISTORY

☐ Yes ☐ No Does your child see an Ear, Nose, and Throat doctor?
If yes, who and why? _____________________________________________

☐ Yes ☐ No Does your child have a history of ear infections, ear drainage, or fluid behind the eardrum?

☐ Yes ☐ No Has your child had PE tubes?

☐ Yes ☐ No Has your child had any other surgeries or hospitalizations that we should know about?
If yes, please describe: ____________________________________________

☐ Yes ☐ No Does your child have vision problems?

☐ Yes ☐ No Does your child have any other diagnosis that we should know about?
If yes, please describe: ____________________________________________

Has your child had any of the following health/medical problems?

☐ ADD/ADHD ☐ Cancer ☐ Genetic Disorder ☐ Meningitis
☐ Allergies ☐ Chicken Pox ☐ Head trauma/injury ☐ Motor Problems
☐ Asthma ☐ Ear Pain ☐ Heart Problems ☐ Mumps
☐ Autism ☐ Ear Ringing ☐ Kidney Problems ☐ Psychiatric Disorder
☐ Balance Difficulties ☐ Exposure to loud noise ☐ Measles ☐ Seizures

DEVELOPMENT HISTORY (complete if it applies to your child)

At what age did your child: Sit alone _______ Walk alone _______ Use first word _______ Use sentences _______

☐ Yes ☐ No Do you have any concerns about your child's speech and language development?
If yes, please describe: ____________________________________________

☐ Yes ☐ No Is your child currently receiving speech, occupational, and/or physical therapy?
If yes, please describe: ____________________________________________

☐ Yes ☐ No Does your child interact well with other children?

EDUCATION HISTORY (complete if your child is enrolled in a school program)

School District: ___________________________________________ Grade Level: ___________________________

☐ Yes ☐ No Does your child currently receive school-based special services?

☐ Yes ☐ No Does your child have an IEP?

☐ Yes ☐ No Does your child have a learning disability or difficulty in school?
If yes, please describe: ____________________________________________

☐ Yes ☐ No Does your child have difficulty concentrating or paying attention in school?

Is there anything else you would like us to know about your child? ____________________________________________