GRACE HEARING CENTER INC

Financial Policy

Welcome to our office! We are pleased that you have chosen Grace Hearing Center to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office. We accept cash, personal checks, and credit cards for payment on your account.

INSURANCE: We do not accept insurance and we expect you to pay for your visit at the time of service.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a $25.00 return check fee charged to your account.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. A collection agency may be used to collect on delinquent accounts. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Grace Hearing Center and have provided to the best of my ability the information requested accurately and completely.

_____ _____

Patients/Responsible Party Signature Date

Grace Hearing Center- Sliding Fee Scale: Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed		Email Address:	

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ / -	-
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

Sliding Fee Scale:

A – Nominal Fee

B – 75% Discount

C – 65% Discount

D – 50% Discount

E – 25% Discount

F- Pay 100%

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Grace Hearing Center, if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Grace Hearing Center I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____

GRACE HEARING CENTER INC

Income & Verification Worksheet

- **Copy of Driver's License or State ID and/or Medicaid ID**
- **Most Recent Paystubs (need at least 2)**
- **Most Recent Income Tax Return (last year or two years)**
- **Bank Statement (last 60 days)**
- **IRA/Investment Income/401K/Stocks/Bonds or other assets**
- **Proof of Residence (utility bill, lease, or other)**
- **Proof of Social Security or Disability Income**
- **Proof of Unemployment Income**
- **Proof of TANF, Food Stamps, or other Financial Assistance Income**
- **Letter of Referral/Support, or Denial of Services (Catholic Charities, or Other Service agencies)**
- **Letter of Denial of Benefits (Medicaid, Insurance, or Other)**
- **Letter of Outstanding circumstance or Medical Expenses**

For Office Use Only.

Monthly Income_____ **Annual Income_____**

Household Size_____ **Total Assets/Savings_____**

Sliding Scale Discount Percentage:_____ **Volunteer Hours_____**

Patient Signature: _____ **Date: _____**

Grace Hearing Representative: _____ **Date:_____**

GRACE HEARING CENTER INC

Confidential Medical and Hearing Health History

It is important that we know all of your medical and hearing health history. Many items have a direct bearing on your hearing health (including the state of your ear canals). We will review the questionnaire and discuss in detail those items that may be of concern. Information you share with us is **strictly confidential** and will not be released without your approval.

NAME: _____ **DOB:**_____

Doctor - Doctor's name PCP: _____

REFERRAL SOURCE

_____ Failed screening

_____ Friend/Patient_____

_____ Other (website/letter/newspaper)_____

Please circle or complete the following questions:

1) **Have you had your hearing tested before?** ..... Yes No Unsure
   What year? _____ Where? _____

2) **Do you have ANY problem hearing?** ..... Yes No Unsure
   How long? _____Which ear? Right ___ Left ___ Both ___

3) **Have you ever worn hearing aids?** ..... Yes No
   How long? _____Which ear? Right ___ Left ___ Both ___

4) **Do family/friends comment about your having difficulty hearing?** .... Yes No Unsure

5) **Anyone in your family, including first cousins, have a hearing loss?** Yes No Unsure
   Who? _____

6) **Are you currently, or have you ever been, exposed to noise/acoustical trauma (i.e. ANY hunting, target practice, power tools, motocross, etc.)**? .... Yes No

7) **Do you hear noises (tinnitus) in your ears or head?** ..... Yes No Unsure
   Right ___ Left ___ Both ___ Constantly ___ Occasionally ___ Unsure ___

8) **Have you had any ear infections?** ..... Yes No Unsure
   When? _____ Right ___ Left ___ Both ___

9) **Have you had any ear surgery?** ..... Yes No Unsure
   When? _____ Right ___ Left ___ Both ___

10) **Do you take medications regularly, including over-the-counter and herbal supplements?** ..... Yes No

    ****Does this include a blood thinner?** ..... Yes No

11) **Do you smoke? If Yes, How often _____Type of Smoking_____.** Yes No

****Complete attached medication list or provide your copy****

Please turn page over to complete this form.

Do you have or have you had:

1.	**Allergies ……..…...……**	**Yes**	**No**	**Unsure**
2.	**Arthritis ……..……..……**	**Yes**	**No**	**Unsure**
3.	**Blood disorder, such as hemophilia ...……**	**Yes**	**No**	**Unsure**
4.	**Cardiovascular disease: arteriosclerosis, coronary insufficiency/occlusion, heart trouble, heart attack, high blood pressure, stroke, …….**	**Yes**	**No**	**Unsure**
5.	**Chemotherapy or radiation treatment ……..**	**Yes**	**No**	**Unsure**
6.	**Diabetes ……..……**	**Yes**	**No**	**Unsure**
7.	**Dizziness/balance problems……..**	**Yes**	**No**	**Unsure**
8.	**Ear pain or fullness ……**	**Yes**	**No**	**Unsure**
9.	**Fainting spells or seizures ….……**	**Yes**	**No**	**Unsure**
10.	**Headaches ……..**	**Yes**	**No**	**Unsure**
11.	**Hives or skin rash, skin allergies ……..……....**	**Yes**	**No**	**Unsure**
12.	**Pacemaker....……...**	**Yes**	**No**	**Unsure**
13	**Persistent cough or cough up blood....…….……..**	**Yes**	**No**	**Unsure**
14	**Preeclampsia (women)...……..…..……..**	**Yes**	**No**	**Unsure**
15.	**Significant weight loss in the last two years……...……..**	**Yes**	**No**	**Unsure**
16.	**Sinus trouble ……..……**	**Yes**	**No**	**Unsure**
17.	**Skull fracture or concussion ……..**	**Yes**	**No**	**Unsure**
18.	**Have you had any surgery including hip replacement? ……..……**	**Yes**	**No**	**Unsure**
	If yes, please list: _____			
19.	**Have you had any serious illnesses? …….……**	**Yes**	**No**	**Unsure**
	If yes, please list: _____			
20.	**Do you have any other diseases, conditions or special concerns <u>not listed above</u> that you think we should know about? _____**			

MEDICAL HISTORY UPDATE

Date	**Changes**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my audiologist, or any other member of this staff, responsible for any errors or omissions that I may have made in completion of this form. I also agree to notify Grace Hearing Center of any changes in my medical status. I agree to allow the Audiologist to practice within the limits of their license.

Signature of Patient_____

Date

GRACE HEARING CENTER INC

www.gracehearing.org

2919 E Broadway Blvd Ste 110
Tucson, AZ 85716
(520) 468-9976

As part of your medical history, please list your current (within the last 6 months) medications, vitamins, and supplements that you are using.

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE (ORAL,IV, ETC)
SIGNATURE:		DATE:	

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We cannot test, provide services, or submit claims without this information.

Patient Information *(Please Print):*

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Referral Source: _____

Address: _____

City_____ State_____ Zip_____

Home Phone: _____Cell Phone: _____ Work_____
Email address: _____
Name of Parent (if applicable) _____

Emergency Contact_____ **Phone** _____

Primary Care Physician (PCP): _____
PCP's Full Address: _____
PCP's Phone #: _____ Fax #:_____

Do you wear hearing aids? Yes/No Model: _____
Serial Number(s) - Right: _____ Left: _____

I authorize the release of any medical or other information necessary to process this claim through my insurance. I authorize payment of medical benefits to the assigned physician or supplier for services rendered.

Signature of Patient: _____**Date:** _____

Patient Name_____ DOB_____

Notice of Privacy Practices for Protected Health Information (HIPAA)
Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by **Grace Hearing Center, Inc** ("Provider") for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment to me by Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant production and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority