Financial Policy

Welcome to our office! We are pleased that you have chosen Oro Valley Audiology 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. If you have insurance, which we do not contract with, you will be expected to make a full payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay and deductible at the time of your visit.

COMMERCIAL/PRIVATE INSURANCE: As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

CONTRACTED INSURANCE: We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.
Initial here
_______ **In the event Grace Hearing Center is not contracted with your health plan, you will be responsible for any out of network, coinsurance, or deductible applied within the sliding scale outlined.**

NO INSURANCE: If you do not have insurance, we expect you to pay for your visit at the time of service.
MEDICARE: We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance 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. Insurance benefits are a matter between you and your insurance company. 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

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

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	**$**

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.

Sliding Fee Scale:

A – Nominal Fee

B – 75% Discount

C – 65% Discount

D – 50% Discount

E – 25% Discount

F- Pay 100%

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:____________**

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

<u>Complete attached medication list or provide your copy**</u>**

<u>Please turn page over to complete this form.</u>

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 not listed above 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 Oro Valley Audiology, Inc. 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

****

Insured Patients: IF YOU HAVE INSURANCE WE NEED TO SUBMIT, PLEASE SIGN BELOW.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the assigned physician or provider for services rendered. If insurance denies coverage or the charges are applied to my deductible, I agree to pay for services rendered. (_____initials). If payment is not made within 90 days of billing, Oro Valley Audiology, Inc. reserves the right to include collection charges.

Signature of Patient: ____

Tanque Verde Audiology

5625 E Grant Rd

Tucson, AZ 85712

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:

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