The Scholl Center at Sound IQ
3105 S. Harvard Ave., Tulsa, OK 74135
Office: (918) 508-7601 Fax: (918) 508-7603
TheSchollCenter.com | SoundIQ.com

MINOR GENERAL

PATIENT INFORMATION

Full name:_________________________________ Preferred name:______________________ Today's date:____________________

DOB: ____/____/_____ Sex: __ Address:_____________________________________ City:_____________ State:____ Zip:_______

Primary Case Physician:______________________________________ Referring Doctor:____

Social Security #:_______-________-________ Direct phone #:_______-________-_______ Secondary phone #:_______-_______-________

Email address:____

RESPONSIBLE PARTY INFORMATION

Last name:_______________________ First name:______________________ Middle Initial:___ Social Security #: _____-_____-_____

DOB:___/____/____ Relationship to Patient:_____________________ Home/Cell #: _____-______-_____ Work #: ______-______-_____

Employer Name: ____ Employer Phone #:______-______-_____

PRIMARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:__________________________ Subscriber's name:_________________________ Policy ID #:________________

Subscriber's DOB:____/____/_____ Group #:________________________ Relationship to Patient:_______________________________

Policy Effective Date:____/____/_____ Insured's Social Security #:_____-______-______ Employer:_______________________________

Employer's #_______-_______-_______

SECONDARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:__________________________ Subscriber's name:_________________________ Policy ID #:________________

Subscriber's DOB:____/____/_____ Group #:________________________ Relationship to Patient:_______________________________

Policy Effective Date:______/______/_____ Insurer's Social Security #:_____-______-______ Employer:____________________________

Employer's #_______-_______-_______

EMERGENCY CONTACT INFORMATION

Emergency Contact:__________________________ Relationship to Patient:____________________ Phone #:_____-______-______

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/ Guardian Print Name:____________________________________ Relationship to Patient:__________________________

Patient/Guardian Signature:____ Date:_________________

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AUTHORIZATION FOR TREATEMENT OF A MINOR/PATIENT

I / We the undersigned parents(s) or legal guardian(s) of the Minor(s) listed below:

____ _______________________

Minor's Full Name Minor's Date of birth

Do hereby authorize any medical treatment to said minor under the general, specific or special consent of:

____ ________________________________

Name of Person Authorized to Bring Minor/Patient Relationship to Minor/Patient

____ ________________________________

Name of Person Authorized to Bring Minor/Patient Relationship to Minor/Patient

____ ________________________________

Name of Person Authorized to Bring Minor/Patient Relationship to Minor/Patient

It is understood that this consent given in advance of and specific diagnosis or treatment being required, but it given to encourage those persons who have custody of the minor, and said physician to exercise their best judgment as the requirements of such diagnosis or medical treatment.

I / We accept full financial responsibility for all medical and health care rendered in response to this letter of authorization.

____ ______________________

(Parent / Legal Guardian Print Name) Date

____ ______________________

(Parent / Legal Guardian Sign Name) Date

This consent will expire 12 months from date listed above.

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MINOR GENERAL

CONFIDENTIAL COMMUNICATION REQUEST

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, ______________________________ (PRINT YOUR NAME) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Telephone Contact Information:

Home #:______-______-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Work #: ______-______-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Cell #: ______-______-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

I want to recieve ☐ text ☐ email notifications.

PLEASE LIST OTHER PERSON THAT MAY BE CONTACTED WITH CONFIDENTIAL INFORMATION

Please note: that if you fail to list parties who can be contacted with confidential information The Scholl Center will not disclose any information about the patient and/or patient treatment including but not limited to: appointment times, test results, medical records, etc.

1. Name:____________________________________ Relationship to Patient:_____________________ Phone #:______-______-_____

2. Name:____________________________________ Relationship to Patient:_____________________ Phone #:______-______-_____

Print Patient Full Name: ____ *DOB:* _____________________

Sign Patient Full Name: ____ *Date:* _____________________

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian ☐ Guardian or Conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient ☐ Other (specify):________________________________

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MINOR GENERAL

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

The Scholl Center for Communication Disorders, P.L.L.C. and its employees are here by authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by The Scholl Center for Communication Disorders, P.L.L.C. and are accessible to its personnel and medical staff for use in my care. The Scholl Center for Communication Disorders, P.L.L.C. personnel and physicians may use and disclose information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. The Scholl Center for Communication Disorders, P.L.L.C. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of The Scholl Center for Communication Disorders, P.L.L.C. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to The Scholl Center for Communication Disorders, P.L.L.C., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for The Scholl Center for Communication Disorders, P.L.L.C. charges payable to the insured are to be made payable to The Scholl Center for Communication Disorders, P.L.L.C. and that insurance benefits for services provided by the physicians in the hospital setting otherwise payable to the insured are to be made payable to the physician(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bill for which you are liable, subject to the rules of coordination of benefits.

PRE-CERTIFICATION POLICY

You understand that The Scholl Center for Communication Disorders, P.L.L.C. will assist with insurance pre-certification requirements which are the responsibility of the policyholder and/or the hospital, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by The Scholl Center for Communication Disorders, P.L.L.C. Charges for services and goods shall be at The Scholl Center for Communication Disorders, P.L.L.C. billed charges unless otherwise agreed to in writing by The Scholl Center for Communication Disorders, P.L.L.C.

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PAGE 2 OF ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

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PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as the original. Signature of Patient of Patient's Legally Authorized Representative (Documentation Must Be Provided)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by The Scholl Center for Communication Disorders, P.L.L.C. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of The Scholl Center for Communication Disorders, P.L.L.C. Notice of Privacy Practices:

Patient Print Name:____

Legal Representative Print Name:_____________________________________ Date :______/_______/________

Patient Sign:____ DOB: ______/______/_______

Basis for refusal, if refused:____

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Office and Financial Policies

INSURANCE, RESCHEDULING, PAYMENT

Thank you for choosing The Scholl Center for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Insurance

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if The Scholl Center is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services, and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. The Scholl Center cannot submit a claim to any insurance carrier if we do not have all the required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific goods or services you are requesting. The Scholl Center commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstances. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

Cancellation Policy

24 HOUR NOTICE

- Hearing Assessments
- Hearing Aid Checks
- Physical Therapy treatment
- Physical Therapy evaluation
- Tinnitus Evaluation
- Cochlear Implant mappings

$25 fee for no-show appointments and late rescheduling.

72 HOUR NOTICE

+ **Balance Evaluation**

Due to the length of appointment and necessary withdrawal of certain medications, there will be no exceptions made for balance evaluations.

$125 fee for no-show appointments and late rescheduling.

NEED TO RESCHEDULE

+ **Inform**

Let us know in the appropriate amount of time if you need to reschedule.

+ **Cancellation fee**

We reserve the right for a cancellation fee for any no show appointments. This is the patient's responsibility and will not be billed to insurance.

Running Late

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 10 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you to come back later in the day if a later appointment is available or reschedule to another date and time.

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INSURANCE, RESCHEDULING, PAYMENT

Payment

Payment in full is due at the time services are provided. You are responsible to pay all out of pocket expenses such as co-pay, co-insurance, and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of any device, accessory, or supplies.

Our Policy

The Scholl Center accepts payment in the form of cash, check, Visa, Mastercard, and Discover. We also offer a third-party credit program through Wells Fargo and AbleTech. *There is a $45 fee for bounced or returned checks.*

It is also the policy of The Scholl Center that we maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charges to your credit card without first informing you of this in writing. You then have the right to use an alternative form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. The Scholl Center reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

☐ *I understand and agree to the office and financial responsibilities of The Scholl Center at Sound IQ.*

☐ *I am the patient.*

Patient Print Name: ____________________ *DOB:* ____________

Patient Signature: ____________________ *Date:* ____________

☐ *I am the parent or guardian of the patient.*

Parent/Guardian Print Name: ____________________ *DOB (of parent/guardian):* ____________

Parent/Guardian Signature: ____________________ *Date:* ____________

Print patient's full name: ____________________ *Patient's DOB:* ____________