ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Legal Name _____ Preferred Name _____
Title First MI Last

Date of Birth_____ Gender _____ Preferred Pronouns (optional) _____

Address _____
Street City State Zip

Phone # (Primary) _____ (Secondary) _____ Social Security Number*_____
*A credit card may be placed on file in lieu of SSN except when billing Medicare, in which case a SSN is required. Obtain additional form from admin.

Email Address _____ Permission to email: Yes / No
Associated Audiologists, Inc. will not share your email address with a third party Opt out of quarterly email newsletter/special offer: Yes / No

Employer Name _____ Employer Phone # _____

Emergency Contact_____
Name Phone Number Relationship

INSURANCE POLICY HOLDER INFORMATION REQUIRED IF OTHER THAN PATIENT (SPOUSE/PARENT/GUARDIAN)

Name _____ Primary Phone # _____
Date of Birth _____ Social Security Number _____
Employer _____ Employer Phone # _____

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Parent/Guardian Name _____ Parent/Guardian Name _____
Primary Phone # _____ Primary Phone # _____

REFERRAL SOURCE - Please select the most influential source that referred you to our practice.

O Physician _____ **O** Internet **O** Newspaper/Magazine
O Family/Friend _____ **O** Insurance/Health Plan **O** Mailing
O Hospital _____ **O** Other _____

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone Number

Other Physician, Person, or Organization _____

I, _____, hereby authorize Associated Audiologists, Inc. to release any and all medical information in the course of my (or my child's) treatment to the physician(s), person(s), or organization(s) listed above.

_____
Signature of Patient or Parent/Guardian Date

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM, THE FOLLOWING MUST BE SIGNED

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Associated Audiologists, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____
Signature of Patient or Parent/Guardian Date

ASSOCIATED AUDIOLOGISTS

AGREEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing us as your Hearing and Vestibular care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy which we require you to read and agree to prior to your medical care.

- Payment of your bill is considered part of your medical care. We require all patients to provide current credit card information for us to keep on file to charge for co-payments, deductibles, and balances not covered by insurance.
- It is your responsibility to know your insurance benefits including whether we are a contracted provider with your insurance company, what your covered benefits are and any exclusions in your policy, and any pre-authorization requirements of your insurance company.
- It is your responsibility to provide current and accurate insurance information at the time of your appointment. Failure to do so will result in you being financially responsible for all costs associated with your medical care.
- If we are contracted with your insurance company, we will bill them first minus any co-pays, deductibles and/or non-covered services that are due. Once insurance has settled, you will be billed for the patient responsibility portion of medical care.
- If we are not contracted with your insurance company, payment in full will be expected at the end of your visit.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that services rendered will be covered by your insurance.

I, _____, authorize Associated Audiologists to charge my credit card for any outstanding balance that is due after applicable insurance reimbursements have been applied for services received at our practice.

Relationship to patient: ☐ Self ☐ Parent / Guardian ☐ Other _____

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card):
Last 4 Digits of Card Number:_____ Expiration Date (mm/yy):____/____ Cardholder Billing Address Zip: _____

Outstanding Balance: Once your insurance provider has completed processing of your claim(s), we will email you a notification indicating any remaining balance due. Payment is due in our office within 48 hours from the date of the email. If payment is not received, or if other arrangements have not been made during that 48 hour period, the entire outstanding balance will be charged to your credit card. Please contact us immediately at 913-384-2105 should you have questions or concerns.

Any credits remaining on your account after your insurance claim has been adjusted will be returned to the credit card on file.

I have read, and understood, the financial policies listed above. My signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that, if my insurance company denies coverage and/or payments for services rendered to me, I assume financial responsibility and will pay all charges in full.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Name of Patient / Responsible Party (please print) Relationship to Patient

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ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Medicare
Railroad Medicare
AARP Medicare Complete
Aetna
Blue Cross/Blue Shield
Cigna Healthcare
First Health
Freedom Network
Humana
Medica Select
Meritain Health/Aetna
Tri-Care
United Healthcare (excluding Community Plan & Oxford)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc. will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy lists a required co-payment, I am responsible for payment of this amount at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. **If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc. accepts payment by Cash, Personal Check, Money Order/Cashiers Checks, MasterCard, Visa, Discover, American Express, Care Credit, or financing thru Wells Fargo. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

_____ _____
Patient/Guardian Signature Date

03/22

ASSOCIATED AUDIOLOGISTS

Associated Audiologists, Inc. – Adult Case History

Patient Name: _____ DOB: _____ Date:_____

List the outcomes you hope to achieve from today's appointment:

_____

Do you have difficulty hearing? ◯ No ◯ Both Ears ◯ Right Only ◯ Left Only

When did you first notice difficulty hearing?_____ Onset was ◯ sudden ◯ gradual

Do you have tinnitus (ringing/sound in your ears)? ◯ No ◯ Both Ears ◯ Right Only ◯ Left Only

How long have you noticed your tinnitus? _____ Onset was ◯ sudden ◯ gradual

Is the tinnitus bothersome? ◯ Yes ◯ No Does it pulse with your heartbeat? ◯ Yes ◯ No

When are you most aware of your tinnitus?_____ Is the sound ◯ constant ◯ intermittent

Describe the sound you hear:_____

Do you have dizziness or imbalance? ◯ Yes ◯ No

When did these symptoms begin? _____ Have you fallen in the past 12 months? ◯ Yes ◯ No

Does anything trigger these symptoms? _____

Review of Systems and Conditions (please check all current or previous symptoms/conditions):

Ear, Nose and Throat
- ☐ Sound Sensitivity
- ☐ Ear Pain
- ☐ Ear Fullness/Pressure
- ☐ Ear Infections
- ☐ Ear Drainage
- ☐ Ear Drum Perforation
- ☐ Ear Surgery
- ☐ Sinusitis/Seasonal Allergies
- ☐ Meniere's Disease
- ☐ Family History of Hearing Loss

Eyes
- ☐ Vision Loss
- ☐ Glaucoma
- ☐ Double Vision
- ☐ Macular Degeneration

Musculoskeletal
- ☐ Pain in Back or Neck
- ☐ Back or Neck Surgery
- ☐ Arthritis

Cardiovascular
- ☐ High/Low Blood Pressure
- ☐ Cardiovascular Surgery
- ☐ Pacemaker

Neurological
- ☐ Facial Numbness or Tingling
- ☐ Numbness in Hands or Feet
- ☐ Headaches/Migraines
- ☐ Seizures
- ☐ Tremors
- ☐ Head Injury
- ☐ Bell's Palsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease/Dementia
- ☐ Stroke/TIA

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Hormone Therapy

Psychiatric
- ☐ Anxiety/Depression
- ☐ Memory Loss
- ☐ Cognitive Changes
- ☐ Other: _____

Systemic and Other
- ☐ Measles
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Lyme Disease
- ☐ Herpes
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Chicken Pox/Shingles
- ☐ Tuberculosis (TB)
- ☐ Meningitis
- ☐ Auto-Immune Disorder
  - Type: _____
- ☐ Kidney Disease
- ☐ Cancer
  - Type: _____
  - Treatment: _____
- ☐ Sleep Apnea
- ☐ Insomnia

Other Medical Conditions:

_____

_____

_____

Have you had noise exposure from any of the following:

Recreational (fire arms/hunting, power tools, etc.): ◯Yes ◯No Hearing protection used: ◯Yes ◯No ◯Sometimes

Occupational (factory, military, farm equipment, etc.) ◯Yes ◯No Hearing protection used: ◯Yes ◯No ◯Sometimes

Previous Evaluations and Testing – If yes, please list location and date:

Hearing Evaluation: _____ ENT Evaluation: _____

Tinnitus Evaluation: _____ MRI/CT Scan of Head: _____

Vestibular Evaluation:_____ Other:_____

Have you used tobacco in the past 24 months? ◯ Yes ◯ No

List all current prescription and over-the-counter medications/supplements, or attach current list.

Name	Reason	Dose	Frequency **How Often**	Route **Oral, Injection, Topical, Etc.**	How Long have you taken it? **Approx.**

Within the past 12 months…[Please indicate: yes or no]		
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, and/or meals?	◯ Yes	◯ No
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	◯ Yes	◯ No
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	◯ Yes	◯ No
4. Has anyone tried to force you to sign papers or to use your money against your will?	◯ Yes	◯ No
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	◯ Yes	◯ No

Associated Audiologists, Inc - Hearing Case History

If you have difficulty hearing or understanding please complete the following questionnaire:

	No	Sometimes	Yes
1. Does your hearing cause you to feel embarrassed when you meet new people?	0 ◯	2 ◯	4 ◯
2. Does your hearing cause you to feel frustrated when talking to members of your family?	0 ◯	2 ◯	4 ◯
3. Do you have difficulty hearing or understanding co-workers, clients or customers?	0 ◯	2 ◯	4 ◯
4. Do you feel handicapped by a hearing problem?	0 ◯	2 ◯	4 ◯
5. Does your hearing cause you difficulty when visiting friends, relatives or neighbors?	0 ◯	2 ◯	4 ◯
6. Does your hearing cause you difficulty in theatres, church or public events?	0 ◯	2 ◯	4 ◯
7. Does your hearing cause you to have arguments with family members?	0 ◯	2 ◯	4 ◯
8. Does your hearing cause you difficulty when listening to the TV, radio or talking on the phone?	0 ◯	2 ◯	4 ◯
9. Do you feel that your hearing limits or hampers your personal or social life?	0 ◯	2 ◯	4 ◯
10. Does your hearing cause you difficulty when in a restaurant with relatives, friends or coworkers?	0 ◯	2 ◯	4 ◯
TOTALS:			

If results indicate that amplification would be beneficial, are you motivated to proceed?

Not motivated 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Absolutely Motivated

What are your goals for a hearing aid? Select ALL that apply

☐ Hearing better in noise ☐ Hearing aids that are automatic ☐ Hearing aids that are rechargeable

☐ Hearing aids that you can't see ☐ Hearing aids that are inexpensive ☐ Hearing aids that use Bluetooth

Of the following, which one holds the most importance in achieving your goals? Select ONE

◯ Cost ◯ Cosmetics ◯ Ease of use ◯ Changing batteries ◯ Durability ◯ Other:_____

Current hearing aid users please complete the following:

How long have you worn hearing aid(s)? _____ Do you wear 1 aid or 2? _____

Current hearing aid make/model? _____ How old are current hearing aids? _____

How often do you wear your current hearing aids? _____

What would you improve about your current hearing aids? _____

Associated Audiologists, Inc.
www.hearingyourbest.com

VESTIBULAR PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Please answer the questions below to the best of your ability. Some of the questions may not be applicable, but please respond as accurately as possible.

When did your problem first occur? _____

Was it associated with a related event (e.g., change in medication, head injury, or illness) ☐ Yes ☐ No
If yes, please explain: _____

Was the onset of your symptoms: ☐ Sudden ☐ Gradual

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES	NO	
☐	☐	Do you experience motion sickness?
☐	☐	Do you experience migraines?
☐	☐	Do you have a family history of migraine?
☐	☐	Have you experienced an injury to the head? If yes, when? _____
☐	☐	Have you had a neck or back injury?
☐	☐	Do you take any medications regularly? If yes, please attach list.
☐	☐	Do you use alcohol? How often_____ Average drinks/week____ Most recent_____
☐	☐	Have you used tobacco in the past 24 months? If yes, how much per day_____
☐	☐	Have you used recreational drugs in the past month?
		If yes, what and how often_____
☐	☐	Are you diabetic? If yes, is it well controlled? ☐ Yes ☐ No
☐	☐	Do you have high/low blood pressure? If yes, is it well controlled? ☐ Yes ☐ No
☐	☐	Have you seen other healthcare providers for your current condition?
		If yes, check all that apply:

✓	Specialist	✓	Specialist
	Cardiologist		Primary Care Physician
	Neurologist		Ear, nose, and Throat (ENT)
	Emergency Department		Psychologist/Psychiatrist

II. If you do not experience issues with your balance, please skip this section and proceed to section III.

YES	NO	
☐	☐	Are you off balance?
☐	☐	Do you have a fear of falling?
☐	☐	Have you fallen in the past 12 months?
		If yes, how many times? _____ When was most recent? _____
☐	☐	Do you veer to either the right or left when walking?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have difficulty walking on uneven surfaces (e.g., up/down stairs or lawn)?
☐	☐	Do you currently or have you ever used an assistive device (e.g., cane, walker, etc.)?
☐	☐	Do you have the benefit of regular exercise?
		If yes, how many times per week? _____ List activities: _____
☐	☐	Have you ever received therapy for your balance?
		If yes, When? _____ Where? _____

(continued) →

III. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES	NO	
☐	☐	Is your dizziness constant? If you answered yes, please go to section IV.
☐	☐	Does your dizziness occur in attacks (comes and goes)? If yes: Each attack typically lasts: ☐ seconds ☐ minutes ☐ hours ☐ days
☐	☐	Do you have any warning that your symptoms are about to start? If yes, what? _____
☐	☐	Is your dizziness worse at any particular time of the day? If yes, when? _____
☐	☐	Do you know of anything that will stop your symptoms or make it better? If yes, what? _____
☐	☐	Do you know of anything that will make your dizziness worse? If yes, check all that apply:

✓	Activity/Situation	✓	Activity/Situation
	Quick head/body movements		Menstrual cycle
	Loud sounds		Rolling over in bed
	Standing up from a lying/sitting down		Bending at the waist
	Looking up		Coughing, sneezing, blowing nose, straining
	Lying down		Bending over
	Large crowds/busy environments		Other:

☐	☐	Do you know of any possible cause of your dizziness? If yes, what? _____

IV. Do you currently experience any of the following sensations?

YES	NO	
☐	☐	Lightheadedness
☐	☐	Swimming sensation in the head
☐	☐	Sensation that you could black out or lose consciousness
☐	☐	Objects are spinning or turning around you
☐	☐	Internal spinning sensation, with objects around you remaining stationary
☐	☐	Rocking/swaying
☐	☐	Foggy headedness

V. Have you ever experienced any of the following sensations? If yes, please *check* the appropriate box and *circle* either "always" or "sometimes."

YES	NO			
☐	☐	Double vision	Always	Sometimes
☐	☐	Blurred vision or blindness	Always	Sometimes
☐	☐	Spots before your eyes	Always	Sometimes
☐	☐	Numbness in face, arms, or legs	Always	Sometimes
☐	☐	Weakness in arms or legs	Always	Sometimes
☐	☐	Confusion or loss of consciousness	Always	Sometimes
☐	☐	Nausea or vomiting	Always	Sometimes

VI. Do you have any of the following symptoms? If yes, please indicate which ear is involved.

YES	NO				
☐	☐	Difficulty hearing? If yes, when did this start? _____	Left Ear	Right Ear	Both
☐	☐	Does your hearing change with your other symptoms?	Left Ear	Right Ear	Both
☐	☐	Noise in your ears or head (i.e., tinnitus)? If yes, does the noise pulse with your heartbeat? _____	Left Ear	Right Ear	Both
☐	☐	Fullness, pressure, or stuffiness in your ears?	Left Ear	Right Ear	Both
☐	☐	Pain in your ears?	Left Ear	Right Ear	Both
☐	☐	Discharge/drainage from your ears?	Left Ear	Right Ear	Both
☐	☐	Have you ever had surgery on your ears?	Left Ear	Right Ear	Both
☐	☐	Have you had your hearing evaluated? If yes, When? _____ By whom? _____ **(if able, please bring to your appointment)**			

Dizziness Handicap Inventory

Name:_____DOB:_____Date:_____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes" (Y), "no" (N) or "sometimes" (S) to each question.

Answer each question as it applies to your dizziness or unsteadiness only.

Item	Question		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are your afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around the house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationship with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	x0	x2

P_____ E_____ F_____ Total_____

Vestibular and Equilibrium
New Patient Instructions and Information

Patient Instructions

Please refrain from excessive alcohol intake **48 hours** prior to your appointment. This may influence or interfere with your test results.

Please inform your audiologist if you have taken the following medications **48 hours** prior to your appointment:

Anti-Vertigo Medications: Antivert, Ru-Vert, Meclizine, etc.

Anti-Nausea Medications: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, scopolamine transdermal.

Please eat lightly prior to your appointment. If your appointment is in the morning, you may have a light breakfast. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

PLEASE DO NOT WEAR MAKEUP (MASCARA, FOUNDATION, ETC.)

Testing may cause a slight sensation dizziness, which may linger after your evaluation. If possible, we encourage you to have someone accompany you to and from the appointment. If this is not possible, please schedule an additional 15 to 30 minutes after your test, so you may wait for the sensation to clear before leaving our office.

ASSOCIATED AUDIOLOGISTS

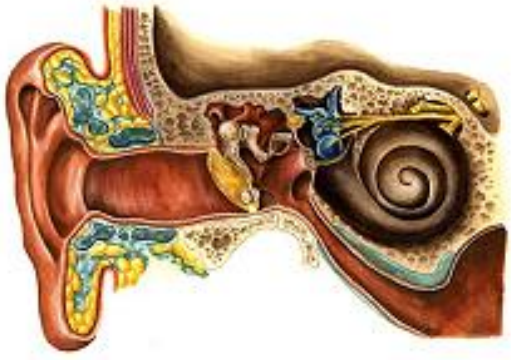
Patient Information

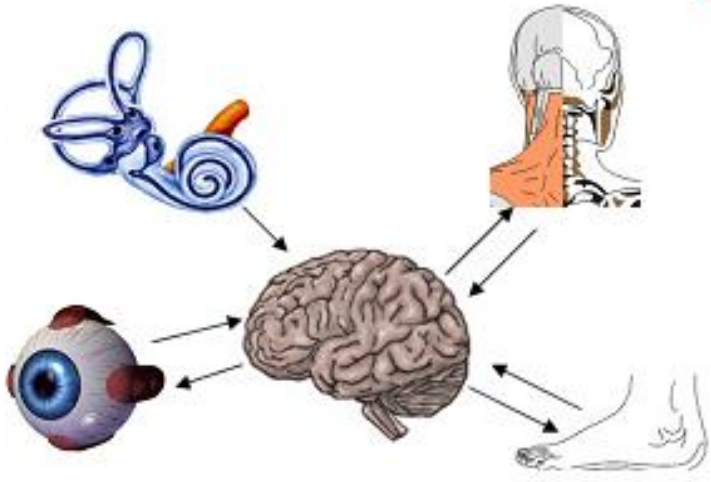
A comprehensive battery of tests will be performed during your evaluation. Prior to each test, a detailed explanation will be given to you, so you gain a better understanding of what we are measuring and what to expect.

Evaluating and Treating Equilibrium Disorders:
Problems with the equilibrium system can result in dizziness, vertigo, and imbalance. The equilibrium system is very complex and cannot be directly observed. To truly understand a patient's equilibrium, a number of sophisticated tests must be performed, correlated, and compared.

-Evaluation-

Balance disorders are often accompanied by changes in hearing and/or ear function. These changes can be acute and hardly noticeable by the patient. Your testing will include comprehensive testing of your outer, middle, and inner ears. These tests include: *audiologic, immittance, and otoacoustic emission* tests.





There are a number of complex pathways that control our equilibrium. Your evaluation will include sophisticated measures of these pathways and your central nervous system. These tests are: *Vestibular Evoked Myogenic Potential, Auditory Brainstem Response, Rotary Chair, Dynamic Visual Acuity, Electro-oculography, Sensory Organization Performance, Vestibular Head Impulse Testing, and Video/Electro-nystagmography*

-Treatment-

There are several well-researched, successful, and widely used treatments and management strategies for problems of the equilibrium system. These treatments address issues such as vertigo, dizziness, lightheadedness, and balance problems. All forms of treatment should be preceded by a comprehensive evaluation and diagnosis. This ensures that the specific treatment chosen is appropriate for the given diagnosis.

ASSOCIATED AUDIOLOGISTS

ASSOCIATED AUDIOLOGISTS

CREDIT CARD ON FILE FAQs

Why do I need to leave a credit card on file? While most of our patients pay their balances in a timely manner, this is not always the case. Neglected balances for services already rendered affect the cost of health care for everyone. This system will streamline billing processes and help keep costs low.

How does having a credit card on file work? At the time of check-in, your credit card will be electronically stored in encrypted form. After your claim has settled, we will email you a notice indicating your total balance due. Payment is expected in our office within 48 hours of the notification. If payment is not received, your card will be charged for any remaining balance that is your responsibility.

Is my credit card information secure? Yes. Credit card numbers are encrypted and stored by Heartland Merchant Processing. No credit card numbers are stored in our practice.

What charges will my card be used for? Your card will only be charged for your patient responsibility once your insurance claim has been settled.

What if my card is declined or expired? If we attempt to use your card and it is declined or has expired, we will contact you for updated information. We reserve the right to charge a $25 administrative fee for any cards that are declined.

What is a deductible and how does it affect me? A deductible is the total dollar amount you must pay during the year for medical expenses before your insurance coverage begins to pay. For example, if your insurance plan has a $500 deductible, you will pay the first $500 of any medical expenses incurred during that year before insurance begins to pay.

What if I don't have a credit card? You may leave a Health Savings Account (H.S.A.) or Flexible Spending card on file with us. You may pay your charges, in full, with cash or check at the time of service. Or, you may speak with us regarding making monthly payments.

How will I know when my deductible has been met? Call your insurance company before your visit to determine how much of your deductible has been met for the year. Or, you may also be able to view your insurance information via the insurance company's website.

What if I have a dispute with my bill? Please contact us immediately at 913-384-2105 so we can promptly address your concerns.

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