UCSF Medical Center

UCSF Benioff Children's Hospital

UCSF Otolaryngology-
Head and Neck Surgery
Cochlear Implant Center
2380 Sutter Street
San Francisco, CA 94115
Tel: (415) 353-2464 Fax:
(415) 353-2603
cochlearImplant@ucsf.edu

Dear Prospective Cochlear Implant Candidate:

Thank you for your inquiry to the UCSF Cochlear Implant Center. We hope the enclosed packet of information answers the majority of your questions regarding cochlear implants, as well as the evaluation process at UCSF Medical Center. Please visit our website https://ohns.ucsf.edu/otology-neurotology/cochlear-implant-center to read about our program, where to find us, what you can expect from a CI, timeline of appointments and how to contact CI device manufacturers

As you are aware, the cochlear implant is a medical prosthesis designed to provide useful hearing to people who receive limited or no benefit from hearing aids. This technology is available for both children and adults. The internal cochlear implant component is surgically placed, and most health insurance providers, including Medicare and Medi-Cal, cover the procedure. The enclosed material details the evaluation and implantation process.

If you are interested in being evaluated for cochlear implantation, please complete the following 5 steps (check each as completed when done):

- ☐ Include a copy of your (or your child's) most recent hearing test.
- ☐ Provide a copy of your (or your child's) immunization records.
- ☐ Have your medical and audiological records sent directly to our office.
- ☐ Provide a copy of the front and back of your insurance card(s).
- ☐ **Complete and return the enclosed forms and questionnaires.**

Once we receive your completed paperwork we will contact you to schedule an evaluation. Additionally, we encourage you to contact some cochlear implant users to discuss their experiences. To obtain contact information, please register on the Advanced Bionics, Cochlear Americas and Med-El websites. They will match you with some implant recipients.

If you have any questions, please do not hesitate to contact us at the numbers below:

Phone: (415) 514-6977
Fax: (415) 353-2603
Email: cochlearimplant@ucsf.edu
Mail: UCSF Cochlear Implant Center
Department of Otolaryngology – Head and Neck Surgery
Attn: Denaya Butler
2380 Sutter Street
San Francisco, CA 94115

UCSF Cochlear Implant Center: Patient information

Patient Information

Patient Name ______________________________

Address ______________________________ **zip code:** ________

Home Phone (___) ______________ Work Phone (___) ______________

Email address: ______________________________

Date of Birth ____/____/____ Gender:: M F Social Security #______________

I request an interpreter for appointments Y N Language ______________

Responsible Party Information

Responsible Party Name ______________________________

Responsible Party Employer ______________________________

Address ______________________________ zip code: ________

Phone (___) __________ Relationship to Patient ______________

Social Security # ______________ **Date of Birth** ____/____/____ **Sex: M F**

Insurance Information

Health Insurance information (please attach a copy of your insurance cards)

Company ______________________________

Policy# ______________ **Group #** ______________

Address ______________________________ **Phone** (___)___-_____

Insured's Name ______________ Insured's **birth date:** __/___/___

Circle patient's relationship to insured: Self Spouse Child Other: ______________

Mental Health Insurance ______________ Policy # ______________

Address ______________________________ Phone (___) ______________

Referring Physician

Referring Physician ______________________________

Address ______________________________

Address ______________________________

Phone (___) ______________ Fax (___) ______________

Primary Physician ______________________________

Address ______________________________

Address ______________________________

Phone (___) ______________ Fax (___) ______________

DOUGLAS GRANT COCHLEAR IMPLANT CENTER
UCSF Medical Center
2380 Sutter Street, First Floor
San Francisco, CA 94115-0342
Phone: (415) 353-2464
Fax: (415) 353-2603
E-mail: cochlearImplant@ucsf.edu
Website: https://ohns.ucsf.edu/otology-neurotology/cochlear-implant-center

INTAKE QUESTIONNAIRE - ADULT

The information in this questionnaire is used to assist us in assessing your candidacy. According to HIPAA laws, all information will be kept confidential. **Please print your responses.** ***Please return this questionnaire to the address shown above. Thank you.***

GENERAL BACKGROUND QUESTIONS

Today's date: ___/___/___

Patient's Name: ____________________________ Gender: M / F Birthdate: ___/___/___ Age____

E-Mail address: ____________________________ Cell / Home phone: (_____) _______-__________

Cell / Home phone: (_____) _______-__________

Person completing this form: self: ______ other: ____

How do you prefer we contact you? Email Mail Phone Other:__________________

1. What is your occupation? ____
   If retired, what was your former occupation? ________________________________
   If you work, do you work full-time or part-time? ☐ F/T ☐ P/T
   Number of hrs worked/week: _________

2. What is your marital/partner status?
   ☐ Single ☐ Married ☐ Divorced
   ☐ Widowed ☐ Separated ☐ Living Together

3. What is your living situation?
   ☐ Live alone ☐ Live with partner/spouse ☐ Live with family member (s)
   ☐ Live with roommates

4. What is your highest level of education completed?
   ☐ Less than high school ☐ High School graduate
   ☐ Trade/Vocational school ☐ Some college
   ☐ College graduate ☐ Graduate School or post-graduate

5. How often do you exercise? ☐ Daily ☐ 3-4 times/week ☐ 1 time/week ☐ Occasionally
   ☐ I do not exercise regularly

6. What other medical problems do you have at this time? ☐ None ☐ If present, please list:
   ___________________________________ ____
   ___________________________________ ____

7. Any surgeries other than for childbirth? ☐ No ☐ Yes, please list type/year::

____

8. Have you had any immunizations? ( ) Yes ( ) No **If yes, please include records; if no, you are unsure, or you do not have access to this information, please state that here:________________

____

8. Any hospitalizations except for childbirth? ( ) No ( ) Yes, please list date and reason:

____

9. Please list all medications, including herbs and over the counter medications:

_____________ ______________ _______________ _______________ _________________

_____________ ______________ _______________ _______________ _________________

10. Vision: Do you use glasses/contacts? ☐ Yes ☐ No
List any vision problems: ____

11. Any problems with your balance or with walking? ☐ No ☐ Yes, please explain:

____

12. Do you have migraine? ☐ Yes ☐ No

13. Have you received a pneumonia vaccine? ☐ No ☐ Yes ☐ Don't know

14. Do you smoke? ☐ No ☐ Yes How many/day _____________

15. Do you drink coffee, tea or cola? ☐ No ☐ Yes How many/day ________________________

16. Sometimes people with hearing loss have symptoms of depression related to problems that are a result of their deafness. Have you ever had counseling before to help cope with hearing loss?
☐ Yes ☐ No If yes, please provide details:

____

____

17. Have you ever seen a counselor for other reasons, such as clinical depression, ADHD, anxiety, using drugs or alcohol to excess, domestic violence, parenting issues, marital or partner issues, learning problems? ☐ Yes ☐ No
If yes, please provide details:____

____

18. Have you ever had medication prescribed to help with psychological problems? ☐ Yes ☐ No

19. How did you learn about the UCSF Cochlear Implant Center?__________________________

____

____

20. Would you like information on local hotels available at special rates? ☐ Yes ☐ No

HEARING LOSS QUESTIONS

HEARING LOSS QUESTIONS

1. What is the **cause** of your hearing loss? ____
2. At what age was your hearing loss **suspected**? ☐ Birth ☐ ____Years
3. How did your hearing loss come on? Slowly ☐ Suddenly/rapidly ☐
4. At what age was your hearing loss **diagnosed**? ☐ Birth ☐ <12 months ☐ ____Years
5. Has your hearing loss **changed** over time? ☐ Yes ☐ No
   If yes, how has it changed? Slowly getting worse ☐ Rapidly/suddenly getting worse ☐
6. Please **describe** your hearing loss by checking one box below for each ear.

Right Ear	Left Ear
☐ No hearing loss	☐ No hearing loss
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Severe	☐ Severe
☐ Total loss	☐ Total loss

7. Do you wear a hearing aid now?
   Right Ear: ☐ Yes ☐ No Left Ear: ☐ Yes ☐ No
8. How much overall benefit do you feel you get from your hearing aid/s?
   Right ear: ☐ A lot ☐ Some ☐ Little ☐ None ☐ Not applicable
   Left ear: ☐ A lot ☐ Some ☐ Little ☐ None ☐ Not applicable
9. If you are **not currently** wearing a hearing aid(s):
   I have worn hearing aids in the past in: ☐ Right ear ☐ Left ear ☐ Not applicable
   I've never worn a hearing aid in: ☐ Right ear ☐ Left ear ☐ Either ear ☐ Not applicable
   I stopped wearing hearing aids in the year: Right ear: ______ Left ear: _______ ☐ Not applicable
   Why did you stop wearing a hearing aid(s)? ☐ Not applicable
   Right ear: ____
   Left ear: ____
   Why have you never worn a hearing aid(s)? ☐ Not applicable
   Right ear: ____
   Left ear: ____
10. Have you ever had any ear surgery? ☐ Yes ☐ No
    If yes, please describe ear and surgery with date(s): ______________________________
11. Do you experience **tinnitus** (ringing/noises in the ears or head)? ☐ Yes ☐ No
    If no, skip to question 13. **If yes,** in which ear do you hear the tinnitus?
    ☐ Right ear ☐ Left ear ☐ Both ears
    How often do you have tinnitus? ☐ Always ☐ Frequently ☐ Rarely
    How much does the tinnitus bother you? ☐ Very little ☐ Somewhat ☐ A great deal
12. Do you experience **vertigo/dizziness**? Yes ☐ No ☐
    If yes, in which ear? ☐ Right ear ☐ Left ear ☐ Don't know
    If yes, how often? ☐ All the time ☐ Frequently ☐ Once in awhile

12. What is your preferred method of communication?
    ☐ ASL ☐ PSE ☐ SEE ☐ Gestures, limited sign, home signs
    ☐ Oral –use voice and speechreading (lipreading), residual hearing
    ☐ Cued speech
    ☐ Writing back and forth

13. Are you able to use the telephone **without** amplifying equipment?
    ☐ Practically always ☐ Almost never
    ☐ Frequently ☐ Never
    ☐ Occasionally

14. Are you able to use the telephone **with** amplifying equipment or special phone?
   - ☐ Practically always
   - ☐ Frequently
   - ☐ Occasionally
   - ☐ Almost never
   - ☐ Never

15. Do you have a caption phone? ☐ Yes ☐ No
   How often do you use your caption phone? ☐ Always ☐ Occasionally

16. Do you use FM equipment? ☐ Yes ☐ No If yes, in what situations? ____________________

   ____

17. Is your home equipped with alerting devices, such as visual smoke detectors, visual alerts for the phone and the door? ☐ Yes ☐ No

18. Do you belong to any organizations for the hard-of-hearing or deaf, such as HLAA, NAD, ALDA?
   ☐ Yes ☐ No

19. Have you ever taken sign language classes or studied sign language videos? ☐ Yes ☐ No

20. Have you taken lipreading classes? ☐ Yes ☐ No

21. Have you attended classes in adjustment to hearing loss? ☐ Yes ☐ No

Thank you for taking the time to complete this information. It is very helpful to the CI team in providing a comprehensive evaluation of your likely benefit from a cochlear implant.

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CONSENT TO FINANCIAL RESPONSIBILITY

Cochlear Implant Evaluation Procedures NOT covered by Medicare and some other insurance plans

In order to determine if you meet the qualifications for a cochlear implant, a series of outpatient tests must be administered. In addition to the standard audiological hearing test a hearing aid evaluation is also completed. The objective of the hearing aid evaluation is to determine whether a hearing aid might provide greater benefit than that anticipated with the implant. We will evaluate your current hearing aids (if you use them) to determine if they are appropriate for you. If other hearing aids may be superior, these will be tried to see if they improve your sound detection and speech understanding. Once appropriate hearing aids have been selected for you, an extensive series of aided auditory speech reception tests are administered.

Because all hearing aids related services are not payable by Medicare, you are responsible for these services. ***Your signature on the following Advance Beneficiary Notice (ABN) form indicates that you agree to pay for the hearing aid procedures.*** Please return the signed form with your application. You will be informed which charges apply the day of your evaluation. The cochlear implant patient selection evaluation **cannot** be completed without these hearing aid services. We ask that you pay for these procedures on the same day of service with a check made out to UC Regents.

See attached ABN form.

Patient's Name: Medicare# (HICN):

ADVANCE BENEFICIARY NOTICE (ABN) .

NOTE; You need to make a choice about receiving these health care items or services.

We xpect that Medicare will not pay for the item(s) or service(s) that are described below. Med1car does not pay {or all of your health care costs, Medicare only pays for covered items ?nd service when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for-

Items or Services:

Hearing aid exam/selection, monaural
Hearing aid exam/selection, binaural
Hearing aid check, monaural
Hearing aid check, bilateral

Electroacoustic analysis. monaural
Electroacoustic analysis, binaural

*Onlv **one** of the above services will be provided and billed to you.

Because:

Not a covered benefit.

The purpos of this fofm is to help you make n informed c oice about whether or not you want to receive these items or services, knowmg that you might have to pay for them yourself. Before. you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost:$ 63.00 - 210.00), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOURCHOICE.

D **Option** 1. **YES.** I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. l understand that you may bill me for items or services and that I may have to pay the bill while Medicare 1s making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can aooeal Medicare's decision.

D.**Option 2. NO.** I have decided not to receive these !terns or services. .

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to aooeal vour opinion that Medicare won't oav.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

0MB Approval No. 0938-0566 Form No. CMS-R-131-G
(June 2002)

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

UCSF Medical Center

PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY* (DOES NOT APPLY TO EMERGENCY SERVICES)

I, ______________________________ have been notified that my health insurance plan may deny payment and/or full
Patient or patients legal representative name - please print

coverage for the following non-emergent service(s): ______________________________
Specific and complete description of service(s)

to be rendered by doctor: ______________________________ on _____ / _____ / _____
Date of service

Estimated Charges: $ ______________ / Deposit: $______________ / Collected: $______________

The "estimated charge" is only an estimate. The actual charges(s) could exceed this amount. You will be required to make full payment of this estimate in advance for any noncovered or nonauthorized services or share-of-cost liability, as payment toward the total charges. Other associated charges could include additional services such as anesthesia, laboratory, x-rays, physician charges, or hospital charges that are **not** included in this estimate. __________ Please initial here acknowledging statement

Patient Liability Reason: Patient and/or guarantor to initial next to liability reason.

__________ Initials

1. No insurance coverage, Managed Care Plans (PPO, HMO, EPO) I understand that these services, which are being provided at my own request:

- ☐ are not covered under my benefit package
- ☐ I request that my insurance not be billed nor notified of this service(s)
- ☐ are conditionally covered under my benefit package
- ☐ are not authorized by my insurance carrier, Primary Care Physician/Primary Medical Group
  - ☐ post stabilization (transfer refusal)

__________ Initials

2. Medi-Cal and/or Medi-Cal Managed Care Plan I understand that Medi-Cal has determined these services, that are being provided at my own request:

- ☐ are not-covered benefits
- ☐ are not authorized by Medi-Cal and/or my Primary Care Physician/Primary Medical Group
- ☐ is designated as a "Share-of-Cost" liability

__________ Initials

3. Medicare

Medicare will only pay for those services that are covered by the program and that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. UCSF Medical Center believes that, in my case, Medicare is likely to deny payment for the scheduled service for the reason below (check one below).

- ☐ Routine physical exams and/or screening procedures
- ☐ Outpatient medications
- ☐ Services related to noncovered services
- ☐ Services are conditionally covered
- ☐ Services not medically reasonable or necessary
- ☐ Other ______________________________
- ☐ Experimental/investigative services
- ☐ Cosmetic surgery
- ☐ Personal comfort items
- ☐ Supportive devices for the feet (non-medically necessary)
- ☐ ABN signed

__________ Initials

4. Financial assistance information provided

__________ Initials

5. Other Reason ______________________________
Describe in detail

Financial Agreement: I have been notified that my health insurance plan may deny payment or full coverage for the service(s) and reason described above. UCSF Medical Center requires that I make payment in advance for "share-of-cost" liability, noncovered, or nonauthorized service(s). By signing this form, I understand and agree to be personally and fully responsible for the payment of this service(s).

Signature of patient or patient representative	(if other than patient, include relationship)	____ / ____ / ____ Date
Signature of guarantor if other than patient	Print Name	____ / ____ / ____ Date
Signature of UCSF Medical Center Representative	Print Name and Department	____ / ____ / ____ Date

This form is utilized after the patient has been provided with the notification of financial assistance and charity care program.

876-070 (Rev. 03/09) WorkflowOne SIGNED COPY TO: WHITE - PATIENT FINANCIAL SERVICES GREEN - DEPARTMENT OF PROF. SERVICE OFFICE CANARY - PATIENT

UCSF Medical Center

UCSF Benioff Children's Hospital

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

FILL IN YOUR CURRENT AUDIOLOGIST'S NAME AT THE (*) AND SIGN AT BOTTOM

I authorize * ______________________
(Name of person or facility which has information - example: UCSF/Mt. Zion)

to release health information to:

UCSF COCHLEAR IMPLANT CENTER

Name of person or facility to receive health information (full address)

2380 Sutter St

Street address:

San Francisco, CA 94115

City, State, Zip Code

P: 415-353-2464; F: 415-353-2603; cochlearImplant@ucsf.edu

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☑ At the request of the patient/ patient representative
- ☐ Other (state reason) ______________________

Please specify the health information you authorize to be released:

Type(s) of health information: Evaluations, reports, progress notes

Date(s) of treatment: ______________________

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- ☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires ____________(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

______________________ Print Name

______________________ Signature (Patient, Parent, Guardian)

______________________ Date Time

______________________ Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Requested format: ☐ Paper ☐ CD

756-020Z (Rev. 02/12) WorkflowOne MEDICAL RECORD COPY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Department of Otolaryngology 2380 Sutter Street, 1st Floor San Francisco, CA 94115 (corner of Sutter and Divisadero)	**Audiology** 2330 Post Street 2nd Floor, Suite #270 San Francisco, CA 94115 (corner of Post and Divisadero)

PARKING RATES

1635 Divisadero Street $2 for each 20 minutes $28 max per day Hours of operation: 5:30 AM to 9:00 PM	***UCSF Valet*** $6 per hour $30 max per day *Handicapped placard* $6 per day
Ampco Parking - 333 Bush St $2 for each 20 minutes $20 max per day **Closes at 6:00 PM **	***2355 Post Street - Valet parking*** $6 per hour Open 24 hours, 7 days per week
1515 Scott Street $3 for each 30 minutes $15 max per day *Hours of operation:* *8:30 AM Closes at 6:00 PM*	***UCSF Patient Parking at 2420 Sutter St *** $7 per hour, $30 max per day Hours of operation: 7:00 AM to 8:30 PM
Kaiser Permanente - 2238 Divisadero St **For Kaiser members:** $1 for each 30 min for the first 3 hours $2 per hour thereafter $16 max per day *Free with ADA placard* **Non-Kaiser members:** $12/hour $60 max/day	Other: Street metered parking $2/hour, 2 hours max. Free resedential parking in the area with various street cleaning limitations-2 hour max. Limited handicap spots as noted above.

UCSF is not responsible for the rates different than above. This informational resource to assist you was updated August 2018. Rates are Subject to change.