PEDIATRIC COMMUNICATION SOLUTIONS
FIND YOUR VOICE

☐ **NORTH OKC**
(PEDIATRIC ENT OF OK)
9900 Broadway Ext
Suite 200
Oklahoma City, OK 73114

☐ **DOWNTOWN OKC**
(HAROLD HAMM DIABETES CENTER)
1000 N. Lincoln Blvd
Suite 3600
Oklahoma City, OK 73104

☐ **NORMAN**
(FRANKLIN BUSINESS PARK)
2761 Washington Dr.
Suite 111
Norman, OK 73069

New Patient Information

Please print - fill in all blanks

Patient's name_____

Gender_____Date of birth_____SSN#_____

Patient's address_____

Phone#1_____#2_____email_____

Preferred language_____Referring physician/pediatrician_____
phone#

Insurance Information

We will need a copy of the insurance card in order to file a claim

Primary Insurance Company_____ID#_____Group#_____

Policy holder name_____Relationship to patient_____

Policy holder's DOB_____Policy holder's SSN#_____Employer_____

☐ N/A Secondary Insurance Company_____

Policy holder name_____Relationship to patient_____

Policy holder's DOB_____Policy holder's SSN#_____Employer_____

Guarantor Information

Name_____Date of Birth_____SSN#_____

Patient's address_____Phone#_____

Employer_____Phone#_____

Employer's address_____

I authorize the release of any medical information if necessary to file insurance claims. I authorize payment of medical benefits to the undersigned provider for the services rendered. I accept responsibility for full payment on my account. I acknowledge and agree that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature Date

PCS PEDIATRIC COMMUNICATION SOLUTIONS
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CASE HISTORY

Please print - fill in all blanks

Patient's name_____

Gender_____Date of birth_____SSN#_____

Patient's address_____

Phone#1_____#2_____email_____

Preferred language_____Referring physician/pediatrician_____
phone#

Mother's name_____Occupation_____

Father's name_____Occupation_____

Does the child live with both parents?_____If no, with whom does the child live with?_____

Siblings (names & ages)_____

Specialists who have seen this child_____

Are there any known diagnoses? (Down syndrome, Autism, Cerebral Palsy, ADD, ADHD, etc?)_____

_____

What language(s) does the child speak?_____

If the child is bilingual, which language is used and understood by the child?_____

What language(s) do the parents speak?_____

What language(s) do the parents speak to the child?_____

How does the child usually communicate? (check all that apply)

☐ gestures ☐ sign language ☐ single words ☐ phrases ☐ sentences

Is the child's speech difficult to understand? ☐ Yes ☐ No

Describe the child's speech, language, fluency, voice, or hearing problem._____

_____

When was the problem first noticed and what who first noticed the problem?_____

_____

What have you done to help your child with the problem?_____

Is there a family history of speech, language, fluency, voice, or hearing problems? If yes, who had the problem?

_____

PRENATAL AND BIRTH HISTORY
Describe the mother's general health during pregnancy (illness, accidents, prescription, nonprescription medications taken, etc.)

_____

Is the child adopted ☐ Yes ☐ No

Is the child in foster care ☐ Yes ☐ No

_____Length of pregnancy _____Length of labor

_____child's general condition at birth _____Birth weight

Type of delivery: ☐ head first ☐ breech ☐ cesarean

Describe any unusual conditions associated with the pregnancy or birth_____

_____

DEVELOPMENTAL HISTORY
Please list the ages your child achieved these milestones:

_____babbled _____sat alone

_____said first word _____crawled

_____put 2 words together _____fed self

_____spoke in short sentences _____toilet trained

CURRENT SPEECH, LANGUAGE, & HEARING
Does your child…

Understand what you are saying?

Retrieve / point to common objects upon request?

Follow simple directions?

Respond correctly to yes / no questions?

Respond correctly to who / what / where / when / why questions?

Have difficulty producing speech sounds?

Frequently stutter when trying to speak?

Communicate with words more often than gestures or crying?

Speak in 2-4 word sentences?

Make eye contact with you / other people?

Become easily distracted?

Check all behavioral characteristics that describe your child:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for a reasonable amount of time
- ☐ separation difficulties
- ☐ easily frustrated
- ☐ impulsive
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted
- ☐ destructive / aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ stubborn

MEDICAL HISTORY

Child's general health is: ☐ Good ☐ Fair ☐ Poor

Please describe any major accidents, surgeries, or hospitalizations the child has had_____

_____

List the child's current medications and dosages _____

_____

EDUCATIONAL HISTORY

School or Preschool_____Grade_____

How is your child doing in school?_____

Does your child have an IEP or an IFSP? _____

Does your child attend Daycare or a Mother's Day Out program?

Daycare: ☐ Yes ☐ No

MDO ☐ Yes ☐ No

Please add any additional information you feel might be helpful in the evaluation or treatment of your child.

_____

_____

Person completing the form_____

Relationship to child_____Date_____

Please attach any report(s) you have from other agencies, schools, or physicians.

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Authorization for treatment

I hereby authorize the provider(s) in charge of the care of the patient of Pediatric Communications Solutions, Inc. to administer treatment as may be deemed necessary or advisable in diagnosis and treatment of this patient.

Authorization for release of medical information

I hereby authorize the provider(s) of Pediatric Communication Solutions, Inc. to disclose any or all of the information in my medical records to any person, corporation or agency which is or maybe liable for all or a part of Pediatric Communication Solutions, Inc. charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the provider's treatment for charge including, carriers, welfare funds, the Social Security Administration of its intermediaries or carriers. I understand my my medical records may contain information that indicates that I have a communicable disease which may include but is not limited to, disease such as hepatitis syphilis, gonorrhea or human immunodeficiency virus, also known as acquired immune deficiency syndrome (Aids). With this knowledge, I give consent to the release of all information my medical records, including information concerning identity comments and release pediatric communications solutions, its agents and its it employees from liability in connection with the release of the information contained therein.

Assignment of insurance benefits

I hereby authorize payment directly to my provider(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Pediatric Communications Solutions, Inc. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances for other amounts do to you from us to any of our affiliates to whom you owe a balance for fees, items for services. We will advise you of any payments we make on your behalf to our affiliates.

Waiver of the responsibility of valuables

I hereby release Pediatric Communication Solutions, Inc. from any claim for a responsibility of damages in the event of loss of my property, including money and jewelry.

I understand a photo copy of this document is as valid as the original.

Policy Holder's Signature_____ Date_____
(PATIENT / LEGAL GUARDIAN)

Policy Holder's Name (PRINT) _____ Relationship to patient_____
(PATIENT / LEGAL GUARDIAN)

NOTICE TO PATIENTS: information in your medical records that you have/may communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release a person who have had risk exposure, release pursuant to an order of the court of the Department of health, release among healthcare providers for released for statistical or epidemiological purposes. Such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by the Court, or the department of health, or by law.

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P:(405) 438-0090 F:(405) 493-0717 pcs-ok.com

INFORMED CONSENT FOR TELETHERAPY

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my speech-language pathologist wishes me to engage in a telehealth consultation.
2. My speech-language pathologist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR COMMERCIAL INSURANCE COPAYMENTS/CO-INSURANCE AMOUNTS IF TELETHERAPY IS NOT A COVERED BY MY INSURANCE POLICY.

CONSENT TO USE THE TELEHEALTH BY CISCO WEBEX

CISCO Webex is the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. CISCO Webex is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither CISCO Webex or Pediatric Communication Solutions, Inc. provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The CISCO Webex Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the CISCO Webex Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the CISCO Webex Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient/Guardian (printed name) Date

_____ _____

Patient/Guardian (signature) Patient's name

PEDIATRIC COMMUNICATION SOLUTIONS
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POLICIES AND PROCEDURES

Pediatric Communication Solutions, Inc. (PCS) is committed to providing a safe, supportive, and welcoming environment for all of our children, parents, students, and staff. To ensure safety and comfort for all we expect all individuals to act in a mature and responsible way that respects the rights and dignity of others. **This applies to all staff, students, parents, family members, and guests who enter our facilities.**

CODE OF CONDUCT

- Pediatric Communication Solutions, Inc. is committed to providing a safe, supportive, and welcoming environment for all of our children, parents, students, and staff. To ensure safety and comfort for all, we expect all individuals to act in a mature and responsible way that respects the rights and dignity of others. **This applies to all staff, students, parents, family members, and guests who enter our facilities.** Our code of conduct does not permit language or action that intimidates, hurts, or frightens another person, or that falls below a generally accepted standard of conduct.

DISCIPLINE POLICY

- Cooperation and a positive attitude of all clients is a vital component of speech language services; therefore, any violent behavior will not be tolerated. Pediatric Communication Solutions, Inc. reserves the right to determine who is or is not suitable for speech-language services and will take all measures to provide a safe and conducive environment for learning. We support a three strikes behavior policy; however, we reserve the right to a zero-tolerance policy regarding violence. In the case of violent behavior by a child, services will be immediately terminated.
    - First offense is a verbal warning.
    - Second offense is a written warning signed by the parent and owner.
    - Third offense will be a consultation with the owner and a possible suspension or termination of services.
- Your child can and will participate fully in speech-language services and will cooperate and accept our guidance in standards of behavior. Failure to adhere to these standards may result in suspension or termination of services.
- We aim to provide a positive learning environment for all children, and we welcome communication with parents anytime.

CONFIDENTIALITY AGREEMENT

- Pediatric Communication Solutions, Inc. understands the sensitivity of the information shared with our staff and strive to keep all information shared private and confidential. To maintain confidentiality, only general information about the individual sessions will be shared in the public areas of the clinics. If you would like to discuss the session in greater detail, our clinicians are available to speak in private during the beginning or end of your child's session(s). All families must sign a this form acknowledging agreement to maintain confidentiality prior to participating in services at Pediatric Communication Solutions, Inc.

PERSONAL BELONGINGS POLICY

- Pediatric Communication Solutions, Inc. is not responsible for any lost, stolen, or damaged items while on the premises of any Pediatric Communication Solutions location.

NON-DISCRIMMINATION

- It is the policy of Pediatric Communication Solutions, Inc. to maintain an environment free of all forms of discrimination and rules for acceptance and participation in speech services are the same for everyone regardless of race, color, ethnicity, religion, or gender.

INSURANCE

- At Pediatric Communication Solutions, Inc. our billing specialist is committed to providing the best experience possible. We will file your insurance claims for you, along with working with you and your insurance company to obtain payment for services. Your insurance coverage is a contract between you and your insurance company and/or you and your employer and insurance company.

_____
Initials

- Your insurance benefits for therapy services will be checked and reviewed with you in detail prior to the first appointment. Please note that a quote of benefits are not a guarantee that therapy will be covered. Your child's diagnosis and treatment plan of care are unique, so never assume the benefits will ensure payment for services rendered.

Reimbursement

- Pediatric Communication Solutions, Inc. accepts most types of insurance as a form of payment. Call the clinic to see if Pediatric Communication Solutions, Inc. is in-network with your insurance carrier/policy.
- Any co-payment/co-insurance/session deductible is due at the time of service. If services are not covered for any reason by your insurance company, you will be responsible for payment in full.

Insurance Agreement

- All members receiving services at Pediatric Communication Solutions, Inc. must agree to our Insurance Agreement. This will be completed prior to the initial evaluation. The insurance agreement is as follows.

This Insurance Agreement (the "Agreement") is made and entered into between ("Legal Guardian") and Pediatric Communication Solutions, Inc.

1. I, Legal Guardian, must make sure the office is aware of any name, address, phone and/or insurance information changes before the appointment.

2. I, Legal Guardian, am responsible for contacting my insurance company and understanding speech-language coverage terms before evaluation or therapy begins at Pediatric Communication Solutions, Inc.

3. I, Legal Guardian, agree to pay for any and all medical/therapy services I receive from Pediatric Communication Solutions, Inc. including those that my insurance company refuses to pay, for whatever reason. Pediatric Communication Solutions, Inc. will file a claim on my behalf (if contracted with my insurance company), however, if my insurance company denies payments for any reason (e.g. non-covered services, services not medically necessary, my failure to obtain a referral, etc.), I will pay these charges promptly upon written/verbal notification of this refusal. If the insurance company requests additional information for processing your claim, Pediatric Communication Solutions, Inc. will promptly comply only one time; there will be no multiple re-filing of claims. It is further understood that no appeals will be filed by Pediatric Communication Solutions, Inc. on my behalf.

4. I, Legal Guardian, understand that failure of my insurance company to pay within 60 days of claim filing date will be considered a refusal to pay and I will be responsible for payment in full due upon receipt of notification.

5. If your account is delinquent, your balance will be turned over to a collection agency and a collection fee of $75.00 or double your balance will be added.

- **DUAL INSUARANCE WAIVER (if applicable):**
  I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR COMMERCIAL INSURANCE COPAYMENTS / CO-INSURANCE AMOUNTS IF MEDICAID DOES NOT AUTHORIZE SERVICES. I HAVE READ, UNDERSTAND AND AGREE THAT I WILL PAY FOR SERVICES NOT COVERED BY MEDICAID.

TERMINATION / DISMISSAL POLICY

- Dismissal/termination of speech and/or language services either permanently or for some specified time period, are set forth in accordance with the American Speech-Language Hearing Association Code of Ethics. The factors for dismissal/termination taken into account include: 1. Individuals shall evaluate the effectiveness of services rendered and of products dispensed and shall provide services or dispense products only when benefit can reasonably be expected. 2. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis. Further, Pediatric Communication Solutions, Inc. has the right to terminate services at any time.

- Termination and /or dismissal may occur due to:
  1. The communication disorder has been remediated or compensatory strategies have been successfully established;
  2. The individual or family chooses not to participate in treatment, relocates, or seeks another provider;

_____
Initials

3. Treatment no longer results in measurable benefits after multiple modifications have been attempted.
4. Attendance has not been adequate to effectively remediate the communication disorder
5. Multiple policies and/or procedures have been violated and terms of agreement between Pediatric Communication Solutions, Inc. and patients have not been successful.
6. Non-compliance with treatment recommendations.
7. Failure or refusal to pay for services.

- It is strongly encouraged that clients speak with the clinician to express any concerns with treatment so that we may resolve any possible conflicts. In accordance with the ASHA code of ethics, if treatment is no longer efficacious, it will be terminated. Pediatric Communication Solutions, Inc. will honor requests to transition services and/or make referrals or recommendations for future clinicians. Please contact our offices during business hours to make arrangements if financial situations arise.

FINANCIAL

Private Pay

- The current session rate for speech-language therapy is $100.00 per session (30 minutes). For families who pay for services on the same day they are provided, we offer a discounted rate. The "same-day payment" rate for a speech-language pathologist (SLP) is $70.00 per session.

Same-Day Discount

- Payment is due in full at the time of service in order to receive our "same-day payment" discount.

Refund Policy

- No refunds will be made for services (evaluations or treatment) already rendered. If at any time, it is determined that a refund should be appropriate for a pre-payment of services that are no longer going to be utilized, the client should speak with the owner to make arrangements.

Credit Card on File Policy

- Pediatric Communication Solutions, Inc. is committed to making our billing process as simple and easy as possible, We require that all patients provide a credit card on file with our office. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim.
- If we do not receive payment for the amount listed on your statement within 30 days, we will run the credit card on file for the full amount owed, unless you have called to setup a payment plan. If your payment is declined, we will call you for an updated card. If our reminder call is not returned within one week, a $25 declined payment fee will be applied, and another statement will be mailed or emailed via QuickBooks. Your account becomes delinquent if not paid within 90 days after the date of the original statement.
- I give Pediatric Communication Solutions, Inc. permission to charge my credit card for any patient balance due on my account.
- I have read a copy of Pediatric Communication Solutions, Inc. Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request.
- If you have any questions, please contact our office at 405-438-0090 or via email at office@pcs-ok.com

SCHEDULING

- Patients will be required to sign up for recurring/standing appointments weekly/monthly. Reschedules are allowed and are detailed within our attendance policy (below). All schedule changes must be made through the front office either via phone, email, or text. Phone: 405-438-0090; email office@pcs-ok.com

ATTENDANCE / CANCELLATION POLICY

- Regular attendance of scheduled therapy sessions is crucial to your child's progress. Therefore, to better serve our growing number of patients and their families, we require everyone to follow our 85% attendance policy and respect our "24-hour cancellation" policy regarding appointment cancellations and rescheduling.

- Our attendance policy is as follows: All clients must maintain 85% attendance for all therapy appointments. Three no shows for scheduled appointments results in immediate discharge. Pediatric Communication Solutions, Inc. reserves the right to discharge patients who do not maintain 85% attendance or violate the "no show/no call" policy. Pediatric

Communication Solutions, Inc. understands that unexpected circumstances can never fully be avoided, and we are more than willing to work with each of you on a case by case basis to resolve any unexpected scheduling issues that may arise occasionally. Please make sure you notify the clinic when you are unable to keep scheduled appointments. If you have any questions or need to reschedule an appointment, please do not hesitate to call the clinic at 405-438-0090. We will be more than happy to work with you.

- In order for your child to continue making progress, our therapists and front office staff can work together with you to reschedule any cancelled/missed appointments. This may mean that another therapist may see your child depending on the rescheduled time and availability.
    - Cancellations must be made through the front desk via phone, email, or text with 24 hours advance notice whenever possible.
    - We understand that kids get sick, and emergencies happen. So, if 24 hours notice is not possible, please call as soon as you can, because we often have clients waiting to be seen who could use your child's cancelled appointment spot.
    - Voicemail is available for you to leave a message anytime 24 hours a day.
    - 1 cancellation per month is allowed, as long as it is rescheduled within the following week (upon availability).
    - We strive to provide 30 minutes of productive treatment each session. Should your child arrive more than 15 minutes late, Pediatric Communication Solutions, Inc. reserves the right to cancel your appointment. If there has been no phone call prior to the appointment start time, that will be counted as a no-show for that day.
    - No-shows should happen only in the case of an emergency, since in most cases, you are able to call, email, or text to cancel an appointment.
    - After 1 or 2 no-show appointments, our office may ask you if we can make schedule changes to better accommodate for your family.
    - In the rare event that a child has 3 no-show appointments in one quarter, they will be removed from the schedule so that another child on the waiting list may be seen.

SICK / ILLNESS POLICY

- It is the policy of Pediatric Communication Solutions, Inc. that in the event the patient becomes ill, the following guidelines will be utilized for re-admitting patients into treatments as listed below:

Cancel appointment if one or more of these conditions are present:

- Fever of 100 degrees or above
- Vomiting, nausea or severe abdominal pain
- Other symptoms suggestive of acute illness

Return to Therapy Guidelines:

- Fever free for full 24 hours without medication
- Symptom free of vomiting, nausea or severe abdominal pain
- All health conditions listed above have been treated and resolved

WAITING ROOM POLICY

- Pediatric Communication Solutions, Inc. aims to provide pleasant, confidential, and highly individualized services. While waiting you may overhear confidential information. It is your obligation to maintain confidentiality. All participating parties agree to our confidentiality agreement (above) by signing this document prior to beginning services.
- Parents are encouraged to attend treatment sessions, however, if your child performs better without you in the room, or if you have other children who would cause a distraction, families are welcome to wait in our lobby during sessions. To provide effective care we ask all patrons to follow the following waiting room policies.
    - No loud conversations or devices in the lobby. Utilizing headphones is preferred, and if you need to take a phone call, we ask that you step outside as a courtesy to the other clients.
    - We understand that children may have snacks with them. We ask that you please keep the area clean and throw away any trash. All drinks should have lids.
    - Due to confidentiality as well as noise level and space constraints, we try to minimize time spent in the lobby. If you would like to consult with your child's therapist, please do so during the beginning or end of their session in the treatment room.

_____
Initials

I HAVE READ, UNDERSTAND AND AGREE TO PEDIATRIC COMMUNICATION SOLUTIONS INC.'S POLICIES AND PROCEDURES.

Legal Guardian / Guarantor printed name _____ Date _____

Legal Guardian / Guarantor signature _____ Patient's Name _____

CREDIT CARD AUTHORIZATION FORM:

Card Type	Visa○ Mastercard○ Discover○ AMEX○ Other: _____
Card Holder's Name:	
Card Number	
CVV Code	
Exp. Date	
Full Billing Address	_____ Street City State Zip Code

I,_____"Legal Guardian" and guarantor for_____ authorize **Pediatric Communications Solutions, Inc.** to charge my credit / debit card above for agreed upon charges. I understand that my payment information will be saved in my file for future payments.

Legal Guardian / Guarantor printed name _____ Date _____

Legal Guardian / Guarantor signature _____

***Policies and procedures may be updated at any time. Pediatric Communication Solutions, Inc. keeps current policies and procedures posted on our website and may also notify you of updates about our policies and procedures via email as necessary.**

_____
Initials

Parental Consent Form

* **Form must be completed in its entirety or will not be accepted**

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I (print name of parent/legal guardian)_____
hereby authorize (print name of provider) _____
to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services that apply) _☐_ Physical Therapy, _☐_ Occupational Therapy and/or _☐_Speech Therapy for child named above.

_____
Signature of Parent/Legal Guardian if a minor

_____
Date Signed by Parent/Legal Guardian

_____
Relationship to Member

_____
Signature of Therapist or Representative of Therapy Group

_____
Date Signed by Provider

Change of Provider

Prior Authorization Form

* Form must be completed in its entirety or will not be accepted
* Effective date of change will depend on current billing cycle
*This form may only be signed by the member, the parent/legal guardian, or the attorney-in-fact
*Facilities and their representatives are not acceptable signatures on the Change of Provider Request Form

Member Name: _____
Member RID #: _____
Service Being Rendered: _____

I (print name of member/parent/legal guardian) * _____
hereby wish to change the above listed services being provided by (print name of previous provider) _____ **to (print name of New provider)** Pediatric Communication Solutions, Inc. **effective** _____**(date the change is to take place).**

_____
Signature of Member of Parent/Legal Guardian if a minor

*

_____
Date Signed by Member/Parent/Legal Guardian

_____
Relationship to Member

****Please Note: OHCA 317:30-3-14(a) states "The Oklahoma Health Care Authority (OHCA) assures that any individual eligible for SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services."**