Electronystagmography (ENG/VNG) Instructions

Welcome to our practice. It is our pleasure to assist Dr. _____________________ in their evaluation of you by performing the vestibular test. The test is called an ELECTRONYSTAGMOGRAPHY (ENG/VNG) and it is a test of the balance mechanism. The test takes approximately 1 to 1½ hours. It is not painful.

We strongly recommend that you have someone bring you to this appointment as you may experience some dizziness that could affect your ability to drive yourself home.

Please read and follow the instructions below so your test results will be valid.

Please do not take any of the following medications during the 48 hours before your scheduled appointment.

Please contact your physician if you have any reservations about discontinuing any drugs.

**Anti-Nausea meds:** Dramamine, Compazine, Bonine, Marezine, Vontrol, Phenergan, Thorazine, Scopolamine transdermal patch (ie; phenergan)

**Anti-Vertigo meds:** Antivert (meclizine), Valium (diazepam), Benadryl (diphenhydarmine), Phenergan

**Tranquilizers:** Valium, Librium, Atarax, Visaril, Equinil, Miltown, Triavil, Serax, and Etrafon

**Sedatives:** Nembutal, Seconal, Dalmane, Doriden, Placidyl, Quaalude, Butisol, or any other sleeping pills

**Narcotics:** Phenobarbital, Codeine, Demoral, Dilaudid, or any other narcotic

**Barbiturates:** Percodan, Percocet, Phenaphen, Fiorcet, or any other barbiturates

**Antihistimines:** Chlor-trimeton, Dimetane, Disop hrol, Benadryl, Actifed, Teldrin, Triaminic, or any other over the counter antihistimine or cold medications

**Alcohol:** Avoid alcohol including beer, wine, and cough medicine that contains alcohol.

You should avoid caffeine and nicotine as well.

We recommend that you sleep a full night before coming in for the test; eat only lightly no later than one hour before the test.

Please refrain from wearing eye makeup or contact lenses, and wear a button down or v-neck shirt.
AUDIOLOGY ASSOCIATES, INC.

Patient Registration

Please complete this packet and bring to your appointment along with insurance card(s) and photo ID. Referrals and co-pays are due at the time of visit.

Patient Name: ___________________________ Date of Birth: ______________________
Social Security #______________________(not applicable under 18) Male:___ Female: ___
Address: __________________________________________________________________
City: ____________________________ State: _________ Zip: ______________________
Phone: __________________________ Alternate Phone: ________________________
E-mail Address: __________________________

Patient Employer: __________________________ Phone: ______________________
Employer Address: _________________________________________________________
City: ____________________________ State: _________ Zip: ______________________

Person Responsible for Payment: ____________________________
Driver’s License #: __________________________ SS #: ______________________

Emergency Contact: __________________________ Relationship: ________________
Phone: __________________________ Alternate Phone: ________________________

Primary Insurance: __________________________ ID #: ______________________
Group #: __________________

Secondary Insurance: __________________________ ID #: ______________________
Group #: __________________

Subscriber’s Name: __________________________
Subscriber’s Date of Birth: ______________________ SS#: ______________________
Relationship to Patient: ____________________________________________

Subscriber’s Employer: __________________________
Address: ____________________________________ Phone: ______________________
City: ____________________________ State: _________ Zip: ______________________

Whom may we thank for referring you? __________________________

Primary Care Doctor: __________________________
Address: ____________________________________
City: ____________________________ State: _________ Zip: ______________________
Phone: __________________________ Fax: __________________________

Report also to: __________________________

PLEASE READ AND SIGN THE FINANCIAL POLICY ON THE BACK OF THIS FORM.

Revised 02/15/2011
Thank you for choosing us as your hearing healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

**COPAYMENTS are due at time of visit.**
**MEDICARE requires a physician’s order for all audiology services.**
**REFERRALS are due at time of visit.**
We accept CASH, CHECKS, VISA, MASTERCARD, & DISCOVER
**MISSED or cancelled appointments without 24-hour notification will incur a $25 fee.**
All REFUNDS are issued via check.

**Regarding Insurance**
Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services rendered may be a non-covered benefit under your plan’s policy and therefore your responsibility. Please check with your insurance carrier. We are participating providers with most insurance carriers. If your insurance company has not paid your claim within 60 days, this office will notify you. If you belong to an HMO or POS it is your responsibility to obtain a referral from your primary physician’s office. If you are seen without a referral, payment will be due at the time of service.

**Usual and customary**
Our practice is committed to providing the best hearing healthcare for our patients, and we charge what is usual and customary for our area. For insurance carriers not contracted with us, you are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

**Past Due Accounts**
Any accounts past due after 90 days will be forwarded to our collection agency. A 30% collection agency fee, court costs and attorney fees will be assessed.

**Check Return Policy**
Returned checks may be assessed up to a $20.00 service charge (per resubmit to bank).

I authorized release of information to primary/secondary insurance companies.
I understand that I am responsible for my bill (Both parent(s) and/or legal guardian(s) are responsible for the minor’s bill).
I authorize payment directly to Audiology Associates, Inc.
I permit a copy of this authorization to be used in place of an original.

I have read the policy above and understand and agree to terms as listed.

X ______________________ Date ______________________
(Signature of pt or responsible party)

X ______________________ Date ______________________
(Signature of co-responsible party)

Please let us know if you have any questions regarding this policy.

Revised 03/30/2016
# Adult History Form

**NAME:** __________________________________________  
**DOB:** __________________________________________

1. **How long have you had difficulty hearing, if any?** __________________________________________

2. **Better ear?**  
- [ ] Right  
- [ ] Left  
- [ ] Same

3. **Pain from ears?**  
- [ ] Yes  
- [ ] No  
Which ear? ____________

4. **Any blocked feeling?**  
- [ ] Yes  
- [ ] No  
Which ear? ____________

5. **Facial numbness?**  
- [ ] Yes  
- [ ] No

6. **Ringing or noises in ears?**  
- [ ] Yes  
- [ ] No  
Which ear? ____________

7. **Have you worn hearing aids?**  
- [ ] Yes  
- [ ] No  
How long? ____________

8. **Do you have any dizziness?**  
- [ ] Yes  
- [ ] No  
How long? ____________

9. **History of ear surgeries/PE tubes?**  
- [ ] Yes  
- [ ] No

10. **Family history of hearing loss?**  
- [ ] Yes  
- [ ] No  
Who? ____________

11. **Worked around or been exposed to loud noises?**  
- [ ] Yes  
- [ ] No  
Where? ____________

12. **Have you had any recent colds?**  
- [ ] Yes  
- [ ] No  
When? ____________

13. **A) Do you have sinus problems?**  
- [ ] Yes  
- [ ] No  
13. **B) Do you have allergy problems?**  
- [ ] Yes  
- [ ] No

14. **History of depression?**  
- [ ] Yes  
- [ ] No

15. **Do you have a pacemaker?**  
- [ ] Yes  
- [ ] No

16. **Health Problems?**  
- [ ] Diabetes  
- [ ] Heart  
- [ ] Circulatory  
- [ ] Head Injury  
- [ ] Head or neck surgery  
- [ ] Radiation/Chemotherapy  
- [ ] Other __________________________

17. **Medications?**  
<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Route</th>
<th>For what medical condition?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Please use back of this form if additional space is needed to list medications**

18. **Known allergies? Please list:** __________________________

19. **Last surgery date?** ____________  
**Procedure:** __________________________

20. **Last hospitalization date?** ____________  
**Reason:** __________________________

21. **Use of alcohol?**  
- [ ] Yes  
- [ ] No

22. **Use of tobacco one or more times in the last 24 months (cigarettes, cigars, smokeless tobacco)?**  
- [ ] Yes  
- [ ] No

Additional comments: __________________________

**Primary Care Physician:** __________________________  
**Phone:** __________________________

**Address:** __________________________  
**Fax:** __________________________

**Report also to:** __________________________

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Updated 04/11/2016
# ABBREVIATED PROFILE OF HEARING AID BENEFIT

**NAME:** _______________________________________

- Last
- First

- [ ] Male
- [ ] Female

**TODAY’S DATE:** ___/___/___

**INSTRUCTIONS:** Please circle the answers that come closest to your everyday experience. Notice that each choice includes a percentage. You can use this to help you decide on your answer. For example, if a statement is true about 75% of the time, circle “C” for that item. If you have not experienced the situation we describe, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave that item blank.

<table>
<thead>
<tr>
<th>Without Hearing Aid</th>
<th>With Hearing Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
<tr>
<td><strong>2.</strong> I miss a lot of information when I’m listening to a lecture.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
<tr>
<td><strong>3.</strong> Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
<tr>
<td><strong>4.</strong> I have difficulty hearing a conversation when I’m with one of my family at home.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
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<td><strong>5.</strong> I have trouble understanding the dialogue in a movie or at the theater.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
<tr>
<td><strong>6.</strong> When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.</td>
<td>A  B  C  D  E  F  G</td>
</tr>
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<td><strong>7.</strong> When I’m at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.</td>
<td>A  B  C  D  E  F  G</td>
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<td><strong>8.</strong> Traffic noises are too loud.</td>
<td>A  B  C  D  E  F  G</td>
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<td><strong>9.</strong> When I am talking with someone across a large empty room, I understand the words.</td>
<td>A  B  C  D  E  F  G</td>
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<td><strong>10.</strong> When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.</td>
<td>A  B  C  D  E  F  G</td>
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<td><strong>11.</strong> When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.</td>
<td>A  B  C  D  E  F  G</td>
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<td><strong>12.</strong> When I am having a quiet conversation with a friend, I have difficulty understanding.</td>
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(Continued)
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**Please fill out these additional items.**

### HEARING AID EXPERIENCE:

- None
- Less than 6 weeks
- 6 weeks to 11 months
- 1 to 10 years
- Over 10 years

### DAILY HEARING AID USE:

- None
- Less than 1 hour per day
- 1 to 4 hours per day
- 4 to 8 hours per day
- 8 to 16 hours per day

### DEGREE OF HEARING DIFFICULTY (without wearing a hearing aid):

- None
- Mild
- Moderate
- Moderately-Severe
- Severe

© University of Memphis, 1994
Audiology Associates, Inc.
Dizziness Questionnaire

Patient Name: ____________________________________   Date:__________________

You have been scheduled for an evaluation with Audiology Associates, Inc. In order to assist the audiologist in providing you with the most comprehensive examination possible, we would like you to take a few minutes to complete the following questionnaire. The information you provide will become part of our permanent medical record. Please be specific and complete as possible.

How many different physicians have you seen in the past for dizziness or balance problem? ____________

When was the first time you experienced dizziness? ________________________________________

What were you doing at the time the first episode occurred? __________________________________

Is the dizziness present continuously or is it intermittent (in spells)?

How often do you experience dizzy spells?__________________________________________________

How long do they last?_________________________________________________________________

Do you feel completely normal between dizzy spells?________________________________________

Do you experience visual difficulties or disturbances? Yes or No  Describe: ______________________

Have you fallen in the last 12 months? Yes or No

If yes, how many falls have you experienced in 12 months? ______________________

If you have fallen, have you been injured? Yes or No    Describe: ___________________________________

Are you dizzy today?  _______________________________________ Please describe: ________________

Do you currently take a Vitamin D supplement?

Please circle all that may apply:
Is your dizziness associated with: Nausea, Vomiting, Sweating, Chest pain, Shortness of breath, Palpitations, Rapid heart beat, Headache, Blurred vision, Temporary blindness, Other visual disturbances, Weakness or numbness of arms or legs, Loss of consciousness, Ringing or noises in your ears

Please circle all that may apply:
Is your dizziness brought on by changes in position: If so, which positions? Rolling over in bed, lying flat, sitting up from a laying position, looking up, bending over, standing from a sitting position

Please circle all that may apply:
Was the onset of your problem with dizziness associated with or preceded by:
A straining episode (heavy lifting, nose blowing, forceful sneezing, a difficult bowel movement)?
Mountain travel, airplane flight, or scuba diving?
Head injury, upper respiratory infection, pain or drainage from ears, a hospitalization, starting or changing a medication, change in eyeglass prescription

Do you have a history of head injury with loss of consciousness, concussion or skull fracture? ________

Do you have a history of noise exposure? _________________________________________________

Have you ever had any type of ear surgery?________________________________________________

Do you have a family history of hearing loss?_______________________________________________

Please circle all that may apply:
Do you have any problems with your hearing?______________________________________________

Right ear    left ear    both ears    how long?____________________________________________

Do you have ringing, buzzing, or humming in your ears?

Right ear    left ear    both ears    how long?____________________________________________
Do you have feelings of fullness or pressure in your ears?

- Right ear
- Left ear
- Both ears
- How long?__________________________

Do you experience any hearing loss, noises in your ears, pressure or fullness that occurs before, during, or after a dizzy spell?  Yes______ No______

Please complete the following statements.
Please give only one answer for each statement.

**Please circle the response that best describes your dizziness.**

I am dizzy:
- Rarely
- Sometimes
- About half the time
- Usually
- Always

When I am dizzy, my symptoms are most often:
- Very mild
- Mild
- Moderate
- Moderately severe
- Severe

When I am experiencing dizziness, it has the following effect on my daily activities, such as working, driving, shopping, taking care of my family, and taking care of myself:

*No effect at all
*I continue all of my daily activities without restriction, although I make allowances for dizziness
*I continue most of my daily activities, although I make allowances for my dizziness
*I continue some of my daily activities, but find that I am unable to continue most functions
*I am unable to continue any of my daily activities

What impact does my condition have on the overall quality of my life? Examples: Participating in social activities, sharing intimate relationships, making plans for the future, obtaining or maintaining work, and participating in leisure activities:

*My condition has no impact on the overall quality of my life
*My condition has some impact on the overall quality of my life
*My condition has moderate impact on the overall quality of my life
*My condition has a great deal of impact on the overall quality of my life
*My condition has a severe impact on the overall quality of my life

Regarding my fear of becoming dizzy:

*I never worry about becoming dizzy
*I seldom worry about becoming dizzy
*I sometimes worry about becoming dizzy
*I frequently worry about becoming dizzy
*I always worry about becoming dizzy

Please describe, without using the word dizziness, exactly what you feel during a dizzy spell:

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
Patient Name: ___________________________ Date of Birth: ________________

Address: _______________________________ City/State/Zip: ________________

Social Security #: _________________________ Phone #: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- This Notice informs me how Audiology Associates Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.

- This Notice explains in more detail how Audiology Associates Inc. may use and share my health information for other than treatment, payment, and health care operations.

- Audiology Associates Inc. will also use and share my health information as required/permitted by law.

- I acknowledge that I received a copy of Audiology Associates Inc.’s Notice of Privacy Practices.

- I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment if amended.

AUTHORIZED BY USE AND DISCLOSURE OF HEALTH INFORMATION

I request and authorize Audiology Associates Inc. to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Choose one option:

__ I consent to Audiology Associates Inc. releasing protected health as detailed below.

If applicable, please list names of family or personal representatives whom we may disclose information to in the event you are unable to contact us directly for any related Audiological questions or needs pertaining to your care and/or financial related issues.

________________________________________

__ I prohibit Audiology Associates Inc. from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

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AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Please check here if you authorize Audiology Associates Inc. to use or disclose your protected health information for marketing related products or services. I understand that Audiology Associates Inc. or its business associates may receive financial remuneration in exchange for making the marketing communication on behalf of the third party whose product or service is being described. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I authorize Audiology Associates Inc. to use and disclose my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, services, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship. This authorization will expire (1) one year from the date it is signed.

Printed name of patient or personal representative

__________________________________________________________ Date: _____________

Signature of patient or personal representative

__________________________________________________________ Date: _____________

Revocation Section

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Audiology Associates Inc. at the address listed below.

Only sign the revocation section below if you wish to revoke all prior authorizations regarding the use and disclosure of your health information:

Revocation: _____________________________________________ Date: _____________

**If you have any questions or need assistance in completing this authorization form, please contact Donna Trostle, at (410) 646-3100**.

Audiology Associates, Inc.
9613-I Harford Road
Baltimore, MD  21234