Melissa J. Segev, Au.D., F.A.A.A.
Briana Bruno Holtan, Au.D., F.A.A.A.
Christina Bradford, Au.D., F.A.A.A.
Arifa Gir, Au.D., F.A.A.A.
Charlotte Godfrey, Au.D., F.A.A.A.

Audiology Associates INCORPORATED

Aimee Kaplan, Au.D., F.A.A.A.
Jessica Verni, Au.D., F.A.A.A.
Corinne Richards, Au.D., F.A.A.A.
Anne Rouleau, Au.D., F.A.A.A.

aaiaudiology.com

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, Disophrol, 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.

AUDIOLOGY ASSOCIATES, INC.
Financial Policy

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

ABBREVIATED PROFILE OF HEARING AID BENEFIT

NAME: _____ ☐ Male ☐ Female TODAY'S DATE: ___/___/___
Last *First*

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.

A Always (99%)
B Almost Always (87%)
C Generally (75%)
D Half-the-time (50%)
E Occasionally (25%)
F Seldom (12%)
G Never (1%)

	Without Hearing Aid	With Hearing Aid
1. When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.	A B C D E F G	A B C D E F G
2. I miss a lot of information when I'm listening to a lecture.	A B C D E F G	A B C D E F G
3. Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.	A B C D E F G	A B C D E F G
4. I have difficulty hearing a conversation when I'm with one of my family at home.	A B C D E F G	A B C D E F G
5. I have trouble understanding the dialogue in a movie or at the theater.	A B C D E F G	A B C D E F G
6. When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.	A B C D E F G	A B C D E F G
7. When I'm at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.	A B C D E F G	A B C D E F G
8. Traffic noises are too loud.	A B C D E F G	A B C D E F G
9. When I am talking with someone across a large empty room, I understand the words.	A B C D E F G	A B C D E F G
10. When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.	A B C D E F G	A B C D E F G
11. 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.	A B C D E F G	A B C D E F G
12. When I am having a quiet conversation with a friend, I have difficulty understanding.	A B C D E F G	A B C D E F G

(Continued)

A Always (99%)
B Almost Always (87%)
C Generally (75%)
D Half-the-time (50%)
E Occasionally (25%)
F Seldom (12%)
G Never (1%)

	Without Hearing Aids	With Hearing Aids
13. The sounds of running water, such as a toilet or shower, are uncomfortably loud.	A B C D E F G	A B C D E F G
14. When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.	A B C D E F G	A B C D E F G
15. When I'm in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.	A B C D E F G	A B C D E F G
16. I can understand conversations even when several people are talking.	A B C D E F G	A B C D E F G
17. The sounds of construction work are uncomfortably loud.	A B C D E F G	A B C D E F G
18. It's hard for me to understand what is being said at lectures or church services.	A B C D E F G	A B C D E F G
19. I can communicate with others when we are in a crowd.	A B C D E F G	A B C D E F G
20. The sound of a fire engine siren close by is so loud that I need to cover my ears.	A B C D E F G	A B C D E F G
21. I can follow the words of a sermon when listening to a religious service.	A B C D E F G	A B C D E F G
22. The sound of screeching tires is uncomfortably loud.	A B C D E F G	A B C D E F G
23. I have to ask people to repeat themselves in one-on-one conversation in a quiet room.	A B C D E F G	A B C D E F G
24. I have trouble understanding others when an air conditioner or fan is on.	A B C D E F G	A B C D E F G

Please fill out these additional items.

HEARING AID EXPERIENCE:	**DAILY HEARING AID USE**	**DEGREE OF HEARING DIFFICULTY (without wearing a hearing aid):**
☐ None	☐ None	☐ None
☐ Less than 6 weeks	☐ Less than 1 hour per day	☐ Mild
☐ 6 weeks to 11 months	☐ 1 to 4 hours per day	☐ Moderate
☐ 1 to 10 years	☐ 4 to 8 hours per day	☐ Moderately-Severe
☐ Over 10 years	☐ 8 to 16 hours per day	☐ Severe

HARL
Hearing Aid Research Lab

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?_____
When was the last time you experienced dizziness?_____
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 experiences 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:

_____
_____
_____
_____
_____
_____
_____

Audiology Associates, Inc.
Health Information Privacy and Affordability Act (HIPAA) Packet

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.

AUTHORIZATION TO 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 <u>authorize</u> 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: _____

<u>Revocation Section</u>

<u>Right to Revoke</u>: 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