Audiology Associates
INCORPORATED

# 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.

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## 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.**

**First Name: _____MI: ___Last Name: _____**
**Date of Birth: _____ Nickname/Preferred Name: _____**
**Parent/Guardian Full Name(s): _____**
**Social Security #_____ (not applicable under 18) Male: ❑ Female: ❑**
**Address: _____**
**City: _____ State: _____ Zip: _____**
**Phone: _____ Alternate Phone: _____**
**E-mail Address: _____**

**Patient Profession: _____**
**Patient Employer: _____ Phone: _____**
**Employer Address: _____**
**City: _____ State: _____ Zip: _____**

**Emergency Contact: _____ Relationship: _____**
**Phone: _____ Alternate Phone: _____**

**Person Responsible for Payment: _____**
**Driver's License #: _____ SS #: _____**

**Primary Insurance: _____ID #: _____**
**Group #: _____**

**Secondary Insurance: _____ID #: _____**
**Group #: _____**
**Subscriber's Name: _____ Relationship: _____**
**Subscriber's Date of Birth: _____ SS#: _____**
**Address if different from patient: _____**
**_____**

**Subscriber's Employer: ❑Same as above _____**
**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 01/18/2018

# AUDIOLOGY ASSOCIATES, INC.
## Financial Policy

**Name: _____ Date of Birth: _____**

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. All co-pays, co-insurances, and deductibles that you have will be billed to you as indicated by your insurance.**
**MEDICARE requires a physician's order for all audiology services.**
**REFERRALS are due at time of visit.**
**We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS.**
**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 make sure that you understand your insurance policy.** 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. All co-pays, co-insurances, and deductibles that you have will be billed to you as indicated by your insurance. 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**, you may be responsible for the full cost of the visit and 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 01/18/2018

# 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.** *Please note that this section is not valid unless page 2 has been signed by the patient or their authorized representative.*

If applicable, please list names of family and/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 on pages 1 and 2 of this packet. 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 **Jaime Lee Fritze, at (410) 944-3100****.

Audiology Associates, Inc.
7113 Ambassador Road
Baltimore, MD 21244

# Audiology Associates, Inc.
## Dizziness Questionnaire

**Patient Name: _____ DOB: _____ 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 □ No Describe: _____

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

If yes, how many falls have you experienced in the last 12 months? _____

If you have fallen, have you been injured? □ Yes □ No Describe: _____

Are you dizzy today? □ Yes □ No Describe: _____

Do you currently take a Vitamin D supplement? □ Yes □ No

**Please check all that may apply:**
Is your dizziness associated with:

| | | |
|---|---|---|
| □ Nausea | □ Chest pain | □ Blurred vision |
| □ Vomiting | □ Shortness of breath | □ Temporary blindness |
| □ Sweating | □ Palpitations | □ Other visual disturbances |
| □ Headache | □ Rapid heartbeat | □ Weakness or numbness of arms or legs |
| □ Ringing or noises in your ears | □ Loss of consciousness | |

**Please check all that may apply:**
Is your dizziness brought on by changes in position:

| | | |
|---|---|---|
| □ Rolling over in bed | □ Lying flat | □ Sitting up from a laying position |
| □ Looking up | □ Bending over | □ Standing from a sitting position |

**Please check all that may apply:**
Was the onset of your problem with dizziness associated with or preceded by:

| | | |
|---|---|---|
| □ Head injury | □ Upper respiratory infection | □ Pain or drainage from ears |
| □ A hospitalization | □ Starting or changing a medication | □ Change in eyeglass prescription |
| □ Mountain travel | □ Airplane flight | □ Scuba diving |

□ A straining episode (heavy lifting, nose blowing, forceful sneezing, a difficult bowel movement)?

Do you have a history of head injury with loss of consciousness, concussion or skull fracture? □ Yes □ No

Do you have a history of noise exposure? □ Yes □ No Describe: _____

Have you ever had any type of ear surgery? □ Yes □ No Describe: _____

Do you have a family history of hearing loss? □ Yes □ No Describe: _____

**Patient Name: _____ DOB: _____ Date: _____**

**Please check 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

Does loud noise trigger your dizziness? □ Yes □ No

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

**Please check 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 INCORPORATED

## Adult History Form

DATE: _____

NAME: _____ DOB: _____

1. How long have you had difficulty hearing, if any? _____
2. Better ear? □ Right □ Left □ Same
3. Pain from ears? □ Yes Which ear? _____ □ No
4. Any blocked feeling? □ Yes Which ear? _____ □ No
5. Facial numbness? □ Yes □ No
6. Ringing or noises in ears? □ Yes Which ear? _____ □ No
7. Have you worn hearing aids? □ Yes How long? _____ □ No
8. Do you have any dizziness? □ Yes How long? _____ □ No
9. History of ear surgeries/PE tubes? □ Yes □ No
10. Family history of hearing loss? □ Yes Who? _____ □ No
11. Worked around or been exposed to loud noises? □ Yes Where? _____ □ No
12. Have you had any recent colds? □ Yes When? _____ □ No
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? Include any over the counter medications, vitamins, herbals, supplements, homeopathic remedies.

| Medications | Dose | Frequency | Method | Medical Condition |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

****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 mos (cigarettes, cigars, smokeless tobacco)? □ Yes □ No

Additional comments: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Address: _____

Report also to: _____

# Hearing Health Quick Test

1. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?
   ☐ Yes ☐ No ☐ Sometimes
2. Do you sometimes feel that people are mumbling or not speaking clearly?
   ☐ Yes ☐ No ☐ Sometimes
3. Do you experience difficulty following dialog in the theater?
   ☐ Yes ☐ No ☐ Sometimes
4. Do you sometimes find it difficult to understand a speaker at a public meeting or a religious service?
   ☐ Yes ☐ No ☐ Sometimes
5. Do you find yourself asking people to speak up or repeat themselves?
   ☐ Yes ☐ No ☐ Sometimes
6. Do you find men's voices easier to understand than women's?
   ☐ Yes ☐ No ☐ Sometimes
7. Do you experience difficulty understanding soft or whispered speech?
   ☐ Yes ☐ No ☐ Sometimes
8. Do you have difficulty understanding speech on the telephone?
   ☐ Yes ☐ No ☐ Sometimes
9. Does a hearing problem cause you to feel embarrassed when meeting new people?
   ☐ Yes ☐ No ☐ Sometimes
10. Do you feel handicapped by a hearing problem?
    ☐ Yes ☐ No ☐ Sometimes
11. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?
    ☐ Yes ☐ No ☐ Sometimes
12. Do you experience ringing or noises in your ears?
    ☐ Yes ☐ No ☐ Sometimes
13. Do you hear better with one ear than the other?
    ☐ Yes ☐ No ☐ Sometimes
14. Have you had any significant noise exposure during work, recreation, or military service?
    ☐ Yes ☐ No
15. Have any of your relatives (by birth) had a hearing loss?
    ☐ Yes ☐ No

## Scoring

2 points for Yes

1 point for Sometimes

0 points for No

**Scores of 3 or more:** May mean that you have a hearing problem.
**Scores of 6 or more:** Strongly suggest that a hearing check is warranted.

If you think you may have a hearing loss, visit **www.HowsYourHearing.org** and click on the "Find an Audiologist" link to locate and set up an appointment with an audiologist in your area to get your hearing checked.

AMERICAN ACADEMY OF AUDIOLOGY