



Welcome to Associated Audiologists Inc!

Thank you for contacting our office to schedule an appointment.

Please note the following:

- We kindly ask that if you are ill or experiencing symptoms of illness that you reschedule your appointment.
- Please arrive 15 minutes prior to your scheduled appointment to allow time to collect your paperwork and prepare your chart. Please complete all enclosed case history and entry paperwork (front and back) prior to check-in.
- Bring the completed forms along with your insurance cards, credit/debit card and picture I.D
- Bring a list of your current medications and over the counter supplements, with dosages.
- If your insurance requires a physician's order, please be sure to request it in time for us to receive it for your appointment. It can be faxed to 913-273-4979.
- Please obtain previous hearing, vestibular, and MRI/CT-Scan test results prior to your appointment. Records can be faxed to 913-273-4979.
- Please do not wear make-up to your appointment, as this may interfere with our test interpretation.
- You will be responsible for any co-payments, co-insurance, or deductible amounts applied by your health insurance plan. A claim will be submitted for consideration and you will be notified of any further balance due after the claim has processed. You will be asked for a credit/debit card to place on file for this appointment. See attached information on this policy.
- Most vestibular testing is billable to insurance; however, depending upon your health insurance plan, certain tests and/or services may be non-covered. These fees could range from \$50-250, and will be due at the time of the appointment.

IMPORTANT – PLEASE READ

Your vestibular audiologist has reserved 2 hours for your testing and consultation. Please extend us the courtesy of 24 hours notice if you are unable to keep your appointment. A cancellation fee of \$100 will be billed if timely notification of cancellation is not received.

We look forward to seeing you soon. If you have any questions prior to your appointment, please do not hesitate to contact our office at **816-642-2626**.

Sincerely,
Nicole Sweet
Vestibular Administrative Assistant

ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Please complete and click on any incorrect information to update as needed.

Legal Name _____ Preferred Name _____
Title First MI Last

Date of Birth _____ Gender _____ Preferred Pronouns (optional) _____

Address _____
Street City State Zip

Phone # (Primary) _____ (Secondary) _____ Social Security Number* _____
*Credit/Debit card may be placed on file in lieu of SSN. Obtain additional form from admin.

Email Address _____ Permission to email: Yes/No
Associated Audiologists, Inc. will not share your email address with a third party Opt out of quarterly email newsletter/special offers: Yes/No

Employer Name _____ Employer Phone # _____

Emergency Contact _____
Name Phone Number Relationship

Insurance: Primary _____ Secondary/Supplement _____

INSURANCE POLICY HOLDER INFORMATION REQUIRED IF OTHER THAN PATIENT (SPOUSE/PARENT/GUARDIAN)

Name _____ Primary Phone # _____
Date of Birth _____ Social Security Number _____
Employer _____ Employer Phone # _____

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Parent/Guardian Name _____ Parent/Guardian Name _____
Primary Phone # _____ Primary Phone # _____

REFERRAL SOURCE - Please select the most influential source that referred you to our practice.

Physician _____	Internet _____	Newspaper/Magazine _____
Family/Friend _____	Insurance/Health Plan _____	Mailing _____
Hospital _____	Other _____	

RELEASE OF MEDICAL INFORMATION

Primary care physician _____
Name City Phone Number

Other Physician, Person, or Organization _____

I, _____, hereby authorize Associated Audiologists, Inc. to release any and all medical information in the course of my (or my child's) treatment to the physician(s), person(s), or organization(s) listed above. *(Please click in the box and sign with mouse or touchpad)*

Signature of Patient or Parent/Guardian Date

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM, THE FOLLOWING MUST BE SIGNED

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Associated Audiologists, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Signature of Patient or Parent/Guardian Date

ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Medicare
Railroad Medicare
AARP Medicare Complete
Aetna
Blue Cross/Blue Shield
Cigna Healthcare
First Health

Freedom Network
Humana
Medica Select
Meritain Health/Aetna
Tri-Care
United Healthcare (excluding Community Plan
& Oxford)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc. will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy lists a required co-payment, I am responsible for payment of this amount at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. **I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc. accepts payment by Cash, Personal Check, Money Order/Cashiers Checks, MasterCard, Visa, Discover, American Express, Care Credit, or financing thru Wells Fargo. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

Patient/Guardian Signature

Date



AGREEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing us as your Hearing and Vestibular care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy which we require you to read and agree to prior to your medical care.

- Payment of your bill is considered part of your medical care. We require all patients to provide current credit card information for us to keep on file to charge for co-payments, deductibles, and balances not covered by insurance.
- It is your responsibility to know your insurance benefits including whether we are a contracted provider with your insurance company, what your covered benefits are and any exclusions in your policy, and any pre-authorization requirements of your insurance company.
- It is your responsibility to provide current and accurate insurance information at the time of your appointment. Failure to do so will result in you being financially responsible for all costs associated with your medical care.
- If we are contracted with your insurance company, we will bill them first minus any co-pays, deductibles and/or non-covered services that are due. Once insurance has settled, you will be billed for the patient responsibility portion of medical care.
- If we are not contracted with your insurance company, payment in full will be expected at the end of your visit.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that services rendered will be covered by your insurance.

I, _____, authorize Associated Audiologists to charge my credit card for any outstanding balance that is due after applicable insurance reimbursements have been applied for services received at our practice.

Relationship to patient: ☐ Self ☐ Parent / Guardian ☐ Other _____

Credit Card Information			
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
	<input type="checkbox"/> Other _____		
Cardholder Name (as shown on card):			
Last 4 Digits of Card Number: _____ Expiration Date (mm/yy): ____/____ Cardholder Billing Address Zip: _____			

Outstanding Balance: Once your insurance provider has completed processing of your claim(s), we will email you a notification indicating any remaining balance due. Payment is due in our office within 48 hours from the date of the email. If payment is not received, or if other arrangements have not been made during that 48 hour period, the entire outstanding balance will be charged to your credit card. Please contact us immediately at 913-384-2105 should you have questions or concerns.

Any credits remaining on your account after your insurance claim has been adjusted will be returned to the credit card on file.

I have read, and understood, the financial policies listed above. My signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that, if my insurance company denies coverage and/or payments for services rendered to me, I assume financial responsibility and will pay all charges in full.

Signature of Patient / Responsible Party

Date

Name of Patient / Responsible Party (please print)

Relationship to Patient

030823 lrc



CREDIT CARD ON FILE FAQs

Why do I need to leave a credit card on file? While most of our patients pay their balances in a timely manner, this is not always the case. Neglected balances for services already rendered affect the cost of health care for everyone. This system will streamline billing processes and help keep costs low.

How does having a credit card on file work? At the time of check-in, your credit card will be electronically stored in encrypted form. After your claim has settled, we will email you a notice indicating your total balance due. Payment is expected in our office within 48 hours of the notification. If payment is not received, your card will be charged for any remaining balance that is your responsibility.

Is my credit card information secure? Yes. Credit card numbers are encrypted and stored by Emerson & Comapny. No credit card numbers are stored in our practice.

What charges will my card be used for? Your card will only be charged for your patient responsibility once your insurance claim has been settled.

What if my card is declined or expired? If we attempt to use your card and it is declined or has expired, we will contact you for updated information. We reserve the right to charge a \$25 administrative fee for any cards that are declined.

What is a deductible and how does it affect me? A deductible is the total dollar amount you must pay during the year for medical expenses before your insurance coverage begins to pay. For example, if your insurance plan has a \$500 deductible, you will pay the first \$500 of any medical expenses incurred during that year before insurance begins to pay.

What if I don't have a credit card? You may leave a Health Savings Account (H.S.A.) or Flexible Spending card on file with us. You may pay your charges, in full, with cash or check at the time of service. Or, you may speak with us regarding making monthly payments.

How will I know when my deductible has been met? Call your insurance company before your visit to determine how much of your deductible has been met for the year. Or, you may also be able to view your insurance information via the insurance company's website.

What if I have a dispute with my bill? Please contact us immediately at 913-384-2105 so we can promptly address your concerns.



VESTIBULAR PEDIATRIC QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Please answer the questions below to the best of your ability. Some of the questions may not be applicable, but please respond as accurately as possible.

When did the problem first occur? _____

Was it associated with a related event (e.g., change in medication, head injury, or illness) Yes No

If yes, please explain: _____

Was the onset of your symptoms: Sudden Gradual

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES NO

Does he/she experience motion sickness?

Does he/she have a family history of motion sickness?

Do he/she experience migraines?

Do you take any medications regularly? If yes, please attach list.

Has he/she experienced an injury to the head? If yes, when? _____

Has he/she lost consciousness because of an injury to the head?

Has he/she had a neck or back injury?

Are they diabetic? If yes, is it well controlled? Yes No

Have you seen other healthcare providers for your current condition?

If yes, check all that apply:

✓	Specialist	✓	Specialist
<input type="checkbox"/>	Cardiologist	<input type="checkbox"/>	Primary Care Physician
<input type="checkbox"/>	Neurologist	<input type="checkbox"/>	Ear, nose, and Throat (ENT)
<input type="checkbox"/>	Emergency Department Doctor	<input type="checkbox"/>	Psychologist/Psychiatrist

II. If he/she does not experience issues with their balance, please skip this section and proceed to section III.

YES NO

☐ ☐ Are they off balance?

☐ ☐ Does he/she have a fear of falling?

☐ ☐ Has he/she fallen in the past 12 months?

If yes, how many times? _____ When was most recent? _____

☐ ☐ Does he/she veer to either the right or left when walking?

☐ ☐ Does he/she have trouble walking in the dark?

☐ ☐ Does he/she have difficulty walking on uneven surfaces (e.g., up/down stairs or lawn)?

☐ ☐ Has he/she ever received therapy for your balance?

If yes, When? _____ Where? _____

(continued) →

III. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES NO

- ☐ ☐ Is the dizziness constant? If you answered **yes**, please go to section IV.
- ☐ ☐ Does the dizziness occur in attacks (comes and goes)? If yes:
Each attack typically lasts: seconds minutes hours days
- ☐ ☐ Do they have any warning that the attack is about to start?
If yes, what? _____
- ☐ ☐ Is the dizziness worse at any particular time of the day?
If yes, when? _____
- ☐ ☐ Is there anything that will stop the dizziness or make it better?
If yes, what? _____
- ☐ ☐ Is there anything that will make the dizziness worse?
If yes, check all that apply:
- | | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Activity/Situation | <input checked="" type="checkbox"/> | Activity/Situation |
| <input type="checkbox"/> | Quick head/body movements | <input type="checkbox"/> | Menstrual cycle |
| <input type="checkbox"/> | Loud sounds | <input type="checkbox"/> | Rolling over in bed |
| <input type="checkbox"/> | Standing up from a lying/sitting down | <input type="checkbox"/> | Bending at the waist |
| <input type="checkbox"/> | Looking up | <input type="checkbox"/> | Coughing, sneezing, blowing nose, straining |
| <input type="checkbox"/> | Lying down | <input type="checkbox"/> | Bending over |
| <input type="checkbox"/> | Large crowds/busy environments | <input type="checkbox"/> | Other: _____ |
- ☐ ☐ Do you know of any possible cause of the dizziness?
If yes, what? _____

IV. Does he/she currently experience any of the following sensations?

YES NO

- ☐ ☐ Lightheadedness
- ☐ ☐ Swimming sensation in the head
- ☐ ☐ Sensation that you could black out or lose consciousness
- ☐ ☐ Objects are spinning or turning around you
- ☐ ☐ Internal spinning sensation, with objects around you remaining stationary
- ☐ ☐ Rocking/swaying
- ☐ ☐ Foggy headedness

V. Have they ever experienced any of the following sensations? If yes, please *check* the appropriate box and select either “always” or “sometimes.”

YES NO

- | | | | | |
|--------------------------|--------------------------|------------------------------------|--------|-----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in face, arms, or legs | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness | Always | Sometimes |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting | Always | Sometimes |

Pediatric Dizziness Handicap Inventory

Name: _____ DOB: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that your child may be experiencing because of his/her dizziness or unsteadiness. Please answer "yes" (Y), "no" (N), or "sometimes" (S) to each question.

Answer each question as it applies to your child's dizziness or unsteadiness only.

Item	Question	Y	N	S
1	Because of your child's problem, is it difficult for him/her to walk unassisted?			
2	Because of his/her problem, does your child feel tired?			
3	Is your child's balance unpredictable?			
4	Does your child use a great deal of effort to keep his/her balance?			
5	Is your child's life ruled by his/her problem?			
6	Does your child's problem make it difficult for his/her to play?			
7	Because of his/her problem, does your child feel frustrated?			
8	Because of his/her problem, has your child been embarrassed in front of others?			
9	Because of his/her problem, is it difficult for your child to concentrate?			
10	Because of his/her problem, is your child tense?			
11	Do other people seem irritated with your child's problem?			
12	Do others find it difficult to understand your child's problem?			
13	Because of his/her problem, does your child worry?			
14	Because of his/her problem, does your child feel angry?			
15	Because of his/her problem, does your child feel "down"?			
16	Because of his/her problem, does your child feel unhappy?			
17	Because of his/her problem, does your child feel different from other children?			
18	Does your child's problem significantly restrict his/her participation in social or education activities, such as going to school, playing with friends, or to parties?			
19	Because of your child's problem, is it difficult for him/her to walk around the house in the dark?			
20	Because of his/her problem, does your child have difficulty walking up or down stairs?			
21	Because of his/her problem, does your child have difficulty walk one or two blocks?			
22	Because of his/her problem, does your child have difficulty riding a bike or scooter?			
23	Because of his/her problem, does your child have trouble reading or doing schoolwork?			
24	Because of his/her problem, does your child have trouble concentrating at school?			
25	Does your child's problem make it difficult to do activities that others his/her age can do?			
		X4	X0	X2

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Total: _____

Vestibular and Equilibrium

New Patient Instructions and Information

Patient Instructions

Please refrain from excessive alcohol intake **48 hours** prior to your appointment. This may influence or interfere with your test results.

Please inform your audiologist if you have taken the following medications **48 hours** prior to your appointment:

Anti-Vertigo Medications: Antivert, Ru-Vert, Meclizine, etc.

Anti-Nausea Medications: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, scopolamine transdermal.

Please eat lightly prior to your appointment. If your appointment is in the morning, you may have a light breakfast. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

PLEASE DO NOT WEAR MAKEUP (MASCARA, FOUNDATION, ETC.)

Testing may cause a slight sensation dizziness, which may linger after your evaluation. If possible, we encourage you to have someone accompany you to and from the appointment. If this is not possible, please schedule an additional 15 to 30 minutes after your test, so you may wait for the sensation to clear before leaving our office.



Patient Information

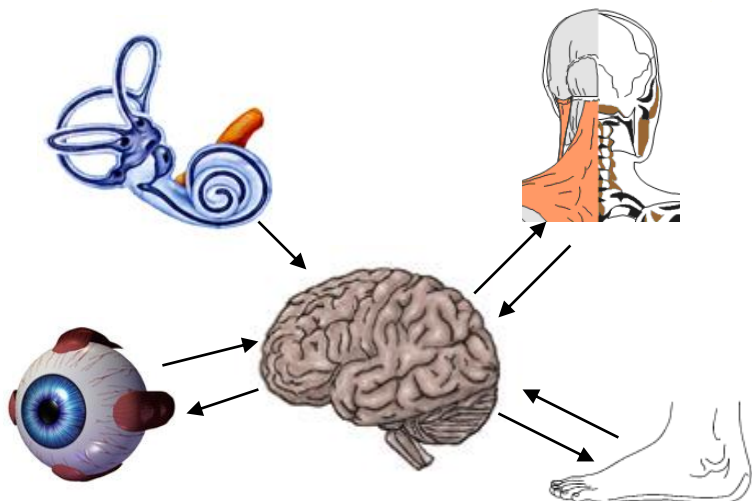
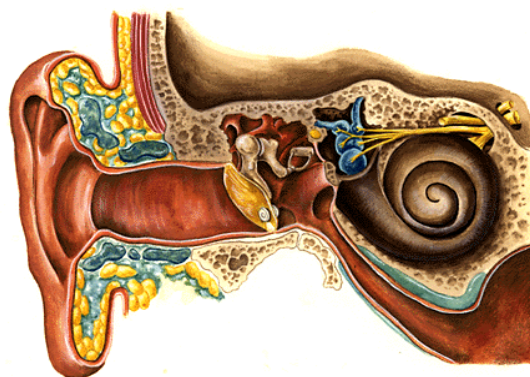
A comprehensive battery of tests will be performed during your evaluation. Prior to each test, a detailed explanation will be given to you, so you gain a better understanding of what we are measuring and what to expect.

Evaluating and Treating Equilibrium Disorders:

Problems with the equilibrium system can result in dizziness, vertigo, and imbalance. The equilibrium system is very complex and cannot be directly observed. To truly understand a patient's equilibrium, a number of sophisticated tests must be performed, correlated, and compared.

-Evaluation-

Balance disorders are often accompanied by changes in hearing and/or ear function. These changes can be acute and hardly noticeable by the patient. Your testing will include comprehensive testing of your outer, middle, and inner ears. These tests include: *audiologic, immittance, and otoacoustic emission* tests.



There are a number of complex pathways that control our equilibrium. Your evaluation will include sophisticated measures of these pathways and your central nervous system. These tests are: *Vestibular Evoked Myogenic Potential, Auditory Brainstem Response, Rotary Chair, Dynamic Visual Acuity, Electro-oculography, Sensory Organization Performance, Vestibular Head Impulse Testing, and Video/Electro-nystagmography*

-Treatment-

There are several well-researched, successful, and widely used treatments and management strategies for problems of the equilibrium system. These treatments address issues such as vertigo, dizziness, lightheadedness, and balance problems. All forms of treatment should be preceded by a comprehensive evaluation and diagnosis. This ensures that the specific treatment chosen is appropriate for the given diagnosis.

