ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

Please complete and correct 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*_____
*SSN required for Medicare billing. Otherwise, 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

REQUIRED: INSURANCE POLICY HOLDER INFORMATION IF OTHER THAN PATIENT (Spouse/Parent/Guardian)

Name _____ Primary Phone # _____
Date of Birth _____ Social Security Number**_____
***Required only with TriCare*

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

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

ASSOCIATED AUDIOLOGISTS

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: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ 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

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Associated Audiologists, Inc. – Pediatric History

Patient Name: _____ DOB: _____ Date:_____

Primary Concern:_____

Does he / she have difficulty hearing/understanding? ◯ No ◯ Both Ears ◯ Right Only ◯ Left Only

When did you first notice difficulty hearing? _____ Onset was ◯ sudden ◯ gradual

Does his/her hearing change (good days/bad days)? ◯ Yes ◯ No

Does he/she have tinnitus (sound in ears)? ◯ No ◯ Both Ears ◯ Right Only ◯ Left Only

How long have they noticed their tinnitus? _____ Onset was ◯ sudden ◯ gradual

Is their tinnitus bothersome? ◯ Yes ◯ No Does it pulse with your heartbeat? ◯ Yes ◯ No

Describe the sound they hear:_____

Does he / she experience dizziness or imbalance? ◯ No ◯ Yes

Describe the dizziness or imbalance: _____

When did these symptoms begin? _____Does anything trigger these symptoms? _____

Review of Systems and Conditions (please check all current or previous symptoms/conditions):

Ear, Nose and Throat
- ☐ Sound Sensitivity
- ☐ Ear Pain
- ☐ Ear Fullness/Pressure
- ☐ Ear Infections
- ☐ Ear Drainage
- ☐ Ear Drum Perforation
- ☐ Ear Surgery
- ☐ Sinusitis/Seasonal Allergies

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disorder

Eyes
- ☐ Vision Loss
- ☐ Double Vision
- ☐ Blindness

Neurological
- ☐ Peripheral Neuropathy
- ☐ Headaches/Migraines
- ☐ Seizures
- ☐ Head Injury
- ☐ Difficulty Breathing

Cardiovascular
- ☐ High/Low Blood Pressure
- ☐ Cardivascular Surgery
- ☐ Fainting / Lightheadedness

Musculoskeletal
- ☐ Decreased Range of Motion
- ☐ Decreased Fine Motor Skills
- ☐ Lack of Coordination
- ☐ Back or Neck Surgery

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ ADD / ADHD
- ☐ Behavior Problems

Infections during Pregnancy
- ☐ Toxoplasmosis
- ☐ Syphilis
- ☐ Rubella
- ☐ Cytomegalovirus (CMV)
- ☐ Herpes

Birth Complications
- ☐ RH Incompatibility
- ☐ Premature
- ☐ Jaundice
- ☐ Low APGAR / Low Oxygen
- ☐ Neonatal Intensive Care (NICU)

Family History
- ☐ Hearing Loss
- ☐ Balance Disorders / Dizziness
- ☐ Headaches / Migraines

Systemic and Other
- ☐ Measles
- ☐ Mumps
- ☐ Tonsillitis
- ☐ Autism
- ☐ Meningitis / Encephalitis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Mononucleosis (Mono)
- ☐ Chicken Pox/Shingles
- ☐ Sickle Cell Anemia
- ☐ Asthma
- ☐ Auto-Immune Disorder
  Type:
- ☐ Kidney Disease
- ☐ Cancer
  Type:
  Treatment:
- ☐ Genetic Disorders/Syndromes:

Other Medical Conditions:_____

(Continue to Page 2)

Exposure to loud noise? Ex. Sporting events, headphone use, concerts, hunting, mowing, etc. ◯ Yes ◯ No

If yes, describe: _____

Previous Evaluations and Testing – If yes, please list location and date:

☐ Hearing Evaluation: _____

☐ Vestibular Evaluation: _____

☐ ENT Evaluation: _____

☐ Hospitalizations: _____

☐ Speech / Language Therapy:_____

☐ Rehabilitations (OT/PT): _____

Other: _____

Passed Newborn Hearing Screening?
◯ Yes ◯ No ◯ Not sure

Review of Developmental Milestones (please select all that apply)

☐ Cooing 0-3 months
☐ Startles to loud sounds 0-3 months
☐ Babbling 4-6 months
☐ Turns head to sounds 4-6 months
☐ Sat alone 5-6 months
☐ Crawled by 7 months
☐ Stood by 7-9 months
☐ Imitates speech 7-9 months
☐ Responds to name 7-9 months
☐ Walked by 9-15 months
☐ First word 10-12 months
☐ Identifies objects 10-12 months

List all current prescription and over-the-counter medications/supplements, or submit current list.

Name	**Reason**	**Dose**	**Frequency** **How Often**	**Route** Oral, Injection, Topical, Etc.	**How Long have you taken it?** Approx.

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Associated Audiologists, Inc.
www.hearingyourbest.com

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
☐	Cardiologist	☐	Primary Care Physician
☐	Neurologist	☐	Ear, nose, and Throat (ENT)
☐	Emergency Department Doctor	☐	Psychologist/Psychiatrist

II. If he/she does not experience issues with their balance, please <u>skip</u> 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:

✓	Activity/Situation	✓	Activity/Situation
☐	Quick head/body movements	☐	Menstrual cycle
☐	Loud sounds	☐	Rolling over in bed
☐	Standing up from a lying/sitting down	☐	Bending at the waist
☐	Looking up	☐	Coughing, sneezing, blowing nose, straining
☐	Lying down	☐	Bending over
☐	Large crowds/busy environments	☐	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**

☐ ☐ Double vision ◯ Always ◯ Sometimes
☐ ☐ Blurred vision or blindness ◯ Always ◯ Sometimes
☐ ☐ Spots before your eyes ◯ Always ◯ Sometimes
☐ ☐ Numbness in face, arms, or legs ◯ Always ◯ Sometimes
☐ ☐ Weakness in arms or legs ◯ Always ◯ Sometimes
☐ ☐ Confusion or loss of consciousness ◯ Always ◯ Sometimes
☐ ☐ 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 difficult 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

D.L. McCaslin et al./International Journal of Pediatric Otorhinolaryngology 79 (2015) 1662-1666

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.

ASSOCIATED AUDIOLOGISTS

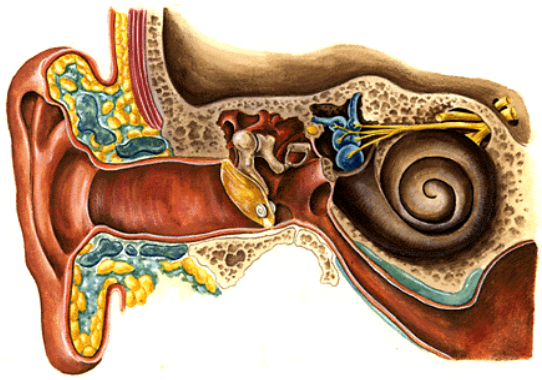
Patient Information

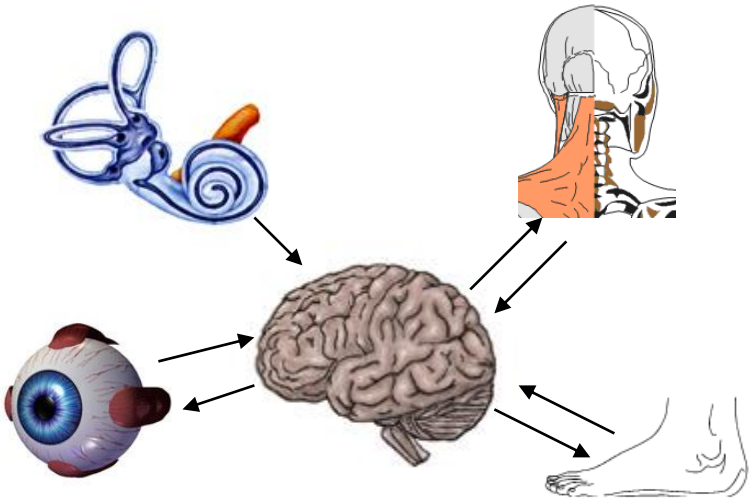
A comprehensive battery of tests will be performed during your evaluation. Prior to each test, a detailed explanation will be given to you, so you gain a better understanding of what we are measuring and what to expect.

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.

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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.

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