ASPIRE
HEARING & BALANCE

Patient Name: _____

Date: _____

# Welcome to Aspire Hearing and Balance!

## Preparing for Your Basic Vestibular Evaluation

Your visit will include a variety of simple but technically advanced tests using specialized equipment. There will be no pins or needle sticks. Your appointment will last approximately 30 minutes.

Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

**Certain medications can influence the body's response to the test, thus giving a false or misleading result. Please discontinue use of the following medications for 48 hours prior to your test (unless specifically instructed by your physician to NOT discontinue use):**

- Allergy medications
- Tranquilizers (Valium, Librium, Xanax, etc.)
- Sedative medications (all sleeping pills of tranquilizers)
- Decongestants/ antihistamines (Benadryl, Sudafed, Dimetapp, etc.)
- Pain medications
- Diet medications
- Nerve/ muscle relaxant medications (Valium, etc.)
- Dizziness medications (Antivert, Meclizine, ear patches, etc.)
- Aspirin or aspirin substitutes (Tylenol, etc.)
- Narcotics/ barbiturates (Codeine, Demerol, Percodan, antidepressants)

**Additional instructions:**

- Please bring your photo ID, insurance card, and medication list to your appointment.
- Wear comfortable clothing and flat, supportive shoes.
- Clean face with minimal to no facial or eye makeup.
- Eat lightly the day of your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.
- No alcoholic beverages/ liquid medication containing alcohol 24 hours before testing.
- Again, vital medications **SHOULD NOT** be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes.

Please contact our office at **863-646-3277** should you have any questions.
Should you need to reschedule your examination, kindly provide 48 hours notice.

ASPIRE
HEARING & BALANCE

## NEW PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR. TODAY'S DATE: _____

PATIENT NAME: _____ PREFERRED NAME: _____

BIRTHDATE: _____ AGE: _____ GENDER (CIRCLE): MALE FEMALE

ADDRESS: _____

CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

PREFERRED METHOD(S) OF CONTACT (CHECK ALL THAT APPLY): ☐ HOME ☐ CELL ☐ EMAIL ☐MAIL

☐ Check here if you do not want us to leave messages on your answering machine or with a family member.
☐ Check here if you do not want us to leave a message on your mobile voicemail.

PRIMARY LANGUAGE: _____ SECONDARY LANGUAGE: _____

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ PACIFIC ISLANDER ☐ CAUCASIAN

EMPLOYED: ☐ NO ☐ YES (EMPLOYER): _____

STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐CHILD ☐ PARTNER

SPOUSE/SIGNIFICANT OTHER'S NAME: _____

**EMERGENCY CONTACT PERSON** (OTHER THAN PATIENT): ☐ SPOUSE ☐ RELATIVE ☐ FRIEND ☐ GUARDIAN

NAME: _____ PHONE: _____

**PRIMARY CARE PHYSICIAN:** _____

REFERRING PHYSICIAN: _____

**INSURANCE INFORMATION:**

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

**HOW DID YOU HEAR ABOUT OUR OFFICE?** _____

**Patient Signature:** _____

ASPIRE
HEARING & BALANCE

## POLICIES AND PROCEDURES

**Welcome to our office. Please read the following information regarding our Policies and Procedures. Thank you!**

### INSURANCE RELATED INFORMATION:

Aspire Hearing and Balance LLC is a participating provider with many insurance carriers in the area. We can assist you in determining whether we are a participating provider for your insurance plan.

Insurance coverage is an agreement between YOU and your insurance carrier. We, as healthcare providers, just execute that agreement for you. Thus, it is your responsibility to determine whether you have out of network benefits (if we are not a provider for your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Aspire Hearing and Balance LLC cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided.

Insurance carriers do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting.

### ASSIGNMENT OF INSURANCE BENEFITS:

I authorize my insurance company to pay and hereby assign directly to Aspire Hearing and Balance LLC all benefits, if any, otherwise payable to me for services as described on the attached forms.

I further expressly agree and acknowledge that my signature on this document authorizes my audiologist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charged incurred. I further acknowledge that any insurance benefits, when received by and paid to Aspire Hearing and Balance LLC, will be credited to my account in accordance with the above said agreement.

### PERMISSION FOR TREATMENT:

Permission is hereby granted for audiologists, audiologists in training, or employees of Aspire Hearing and Balance LLC to render such medical treatment as is deemed necessary.

### AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains electronic records describing your health history, symptoms, examinations, test results, diagnoses, and treatment, any plans for future care or treatment and payment for services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals and entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

“Only as permitted or required by federal or state law”, we may use your protected healthcare information to do the following:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment, an/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s) other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voicemail, or with a household family member.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- You may request a copy of, or as a new patient, will be given a copy of our "*Notice of Patient Privacy Practices*" that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.
- You have read or have had the right to read the "*Notice of Patient Privacy Practices*" prior to signing this authorization.

**POLICY ON RESPONSIBILITY FOR PATIENT FEES:**

To communicate effectively, we have created this policy to help the undersigned understand the responsibilities for payment of our fees. If at any time you as the responsible party have questions or problems with our fees or payment process, please don't hesitate to contact our office at 863-646-3277.

We require all charges be paid promptly as we present them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge, it means that we have taken any such adjustment into account and that the amount remaining must be promptly paid at that time. If you are to be reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by the insurance company or government program, that matter is between the responsible part and that program. We are happy to provide factual information about the patient's care and billing to assist in appeals with such entities, but we still require the charges be paid promptly, even if the issue with any reimbursement program has not been resolved.

Payment for our services is due at the time that those services are provided, and we expect that all charges we present at a visit will be paid at the time of visit. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as patient-responsible party's duty to pay after coverage by insurance or government programs. We may also present charges by written statement via the mail, e-mail if authorized by the patient, or through our Patient Portal following a visit. If we do this, we expect that each charge will be paid in fill by return mail or through the Patient Portal online bill payment system the first time it is presented.

We or our agents may send statements and reminders of charges made and amounts that we believe must be paid, or may call the undersigned about the same. By accepting our services, the undersigned is consenting to receive these communications.

In consideration or the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay responsible attorney's fees and collection expenses. At present, that fee is a minimum of 30% of charges collected and is payable before the patient is seen in the office of Aspire Hearing and Balance LLC at next visit. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

**Cancellation Policy, "No Show" Fees, and Late Arrival Policy**

We require that you give our office at least 48 business hour notice if you need to cancel or reschedule an office or diagnostic testing appointment. Business hours are Monday through Friday from 8:30am to 4:00pm. There will be a $35.00 fee for any missed appointments or late cancellations with less than 24 hours notice. If you cancel or reschedule

your appointment more than two times, we will be forced to take credit card information to keep on file and charge a $75 cancellation fee if the next visit (3rd) is cancelled or rescheduled.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment. We will try to accommodate you if time allows. Otherwise, we will need for you to come back later in the day or reschedule for another day and time.

Other Fees:

After receiving your signed authorization, we will send medical records at your request to the physician of your choice free of charge. All other requests for release of confidential information have the following charges:

$1.00 per page – up to 25 pages
$.25 cents per page – 26 pages or more

The following fees apply for the documents below if the request is not made during an office visit:

Audiologist statement or letter - $25.00-$250.00 depending on time and records review

**Payments**

Aspire Hearing and Balance LLC accepts payment in the form of cash, checks, Visa, Mastercard, Discover, and American Express. We also offer a third-party credit program through Allegro Credit or CareCredit. There will be a $30 fee for all bounced or returned checks.

ASPIRE
HEARING & BALANCE

**SIGNATURE FORM**

The undersigned has read and agrees to the information stated above:

- Notice of Privacy Practices for Protected Health Information
- Assignment of Insurance Benefits
- Permission for Treatment
- Authorization for the Use or Disclosure of Health Information for Treatment or Payment
- Policy on Responsibility for Patient Fees

**Signature** (*Required)*: _____ Date Signed: _____

**If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**DISCLAIMERS: Please initial next to each disclaimer.**

_____ As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-payment, deductibles, or not covered procedures. Your insurance must be on file at the time of your appointment.

_____ By initialing this section and signing below, I hereby authorize Aspire Hearing and Balance LLC to send me educational and/or marketing information on the products and/or services offered by Aspire Hearing and Balance LLC. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ *Medicare patients only*: Medicare will cover hearing testing if your physician has ordered such testing for a diagnostic medical evaluation or to determine the appropriate medical or surgical treatment or a hearing deficit or related medical problem. Medicare **will not** cover hearing testing for routine hearing evaluations to check your hearing status and adjust your hearing aids.

_____ I understand that if I am seen without a referral from my primary care physician and my health plan required that I obtain that referral, then my health plan may not cover the charges, costs, or expenses of my care from Aspire Hearing and Balance LLC and in that case I will be responsible for the total balance.

ASPIRE
HEARING & BALANCE

Patient Name: _____

Date: _____

# Balance Patient Questionnaire

**Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.**

How or when did your problem first occur? _____

How long did it last? _____

**I. Do you experience any of the following sensations?**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Do you experience motion, air, or sea sickness? |
| ☐ | ☐ | Did you have motion sickness as a child? |
| ☐ | ☐ | Do you have a family history of motion sickness? If so, ☐ Parent ☐ Sibling ☐ Child? |
| ☐ | ☐ | Do you have migraine headaches? |
| ☐ | ☐ | Were you exposed to any solvents, chemicals, etc.? |
| ☐ | ☐ | Have you ever fallen? If so, How many times? _____ Where? _____ |
| ☐ | ☐ | Are you afraid of falling? |

**II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | My dizziness is constant? If you answered yes, please go to section III. |
| ☐ | ☐ | Does you experience dizziness in “attacks”? If so, how often? _____ |
| ☐ | ☐ | Are you completely free of dizziness between attacks? |
| ☐ | ☐ | Do you have any warning that the attack is about to start? |
| ☐ | ☐ | Is the dizziness provoked by head/body movement? If so, which direction? _____ |
| ☐ | ☐ | Is the dizziness worse at any particular time of the day? If so, when? _____ |
| ☐ | ☐ | Do you know of anything that will stop your dizziness or make it better?<br>What? _____ |
| ☐ | ☐ | Do you know of anything that will make your dizziness worse?<br>What? _____ |
| ☐ | ☐ | Do you know of anything that will precipitate an attack?<br>What? _____ |
| ☐ | ☐ | Do you know of any possible cause to your dizziness?<br>What? _____ |

ASPIRE
HEARING & BALANCE

Patient Name: _____

Date: _____

**III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Light headedness? |
| ☐ | ☐ | Swimming sensation in the head? |
| ☐ | ☐ | Blacking out or loss of consciousness? |
| ☐ | ☐ | Objects spinning or turning around you? |
| ☐ | ☐ | Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| ☐ | ☐ | Tendency to fall……. to the right or left? |
| ☐ | ☐ | Tendency to fall……. forward or backward? |
| ☐ | ☐ | Loss of balance when walking…… veering to the right? |
| ☐ | ☐ | Loss of balance when walking…… veering to the left? |
| ☐ | ☐ | Do you have trouble walking in the dark? |
| ☐ | ☐ | Do you have problems turning to one side or the other? |
| ☐ | ☐ | Nausea or vomiting? |
| ☐ | ☐ | Pressure in the head? |

**IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and check the box if Constant or if In Episodes.**

| YES | NO | | | |
|---|---|---|---|---|
| ☐ | ☐ | Double vision? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Blurred vision or blindness? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Spots before your eyes? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Numbness of face, arms or legs? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Weakness in arms or legs? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Confusion or loss of consciousness? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Difficulty in swallowing? | ☐ Constant | ☐ In Episodes |
| ☐ | ☐ | Difficulty speaking? | ☐ Constant | ☐ In Episodes |

**V. Do you have any of the following? Please check the box for either YES or NO and check the ear(s) involved.**

| YES | NO | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | Difficulty in hearing? | ☐ Both Ears | ☐ Right Ear | ☐ Left Ear |
| | | When did this start? _____ Is it getting worse? _____ | | | |
| | | Does the hearing change with your symptoms? _____ If so, how? _____ | | | |
| ☐ | ☐ | Noise in your ears? | ☐ Both Ears | ☐ Right Ear | ☐ Left Ear |
| | | Describe the noise _____ | | | |
| | | Does the noise change with your symptoms? _____ If so, how? _____ | | | |
| | | Does anything stop the noise or make it better? _____ | | | |
| ☐ | ☐ | Fullness or stuffiness in your ears? | ☐ Both Ears | ☐ Right Ear | ☐ Left Ear |
| | | Does this change when you are dizzy? _____ | | | |
| ☐ | ☐ | Pain in your ears? | ☐ Both Ears | ☐ Right Ear | ☐ Left Ear |
| ☐ | ☐ | Discharge from your ears? | ☐ Both Ears | ☐ Right Ear | ☐ Left Ear |

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HEARING & BALANCE

Patient Name: _____

Date: _____

# Past Medical History

**Please mark any of the following that you currently have or have had in the past:**

- ☐ Migraine
- ☐ Stroke/TIA
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Head Injury
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Scarlet Fever
- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Syphilis
- ☐ Measles
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ HIV/AIDS
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Vision Loss
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Cancer (Type: _____)
- ☐ Rheumatoid Arthritis
- ☐ Gastrointestinal Problems
- ☐ Meningitis
- ☐ COVID
- ☐ Other: _____

**Do you smoke?** ☐ YES ☐ NO

If so, how many packs per day?

☐ Less than ½ ☐ ½ - 1 ☐ 2-3 ☐ 4+

**Do you drink alcohol?** ☐ YES ☐ NO

If so, how many drinks per day?

☐ 1 ☐ 2-5 ☐ 6+

**Do you drink caffeine products?** ☐ YES ☐ NO If so, what kind of caffeine products? ☐ Tea ☐ Soda ☐ Coffee

If you drink caffeine products, how many cups per day? ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

**Allergies (medications or other):** _____

**Please list all of your current medications, over the counter drugs, and supplements.**

| PRESCRIPTION NAME | DOSAGE/STRENGTH | FREQUENCY | REASON |
|---|---|---|---|
| | | | |
| | | | |
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Patient Name: _____

Date: _____

Initial Visit / Follow-Up / Discharge

# The Dizziness Handicap Inventory (DHI)

**PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS.**

| | | YES 4 | SOMETIMES 2 | NO 0 |
|---|---|---|---|---|
| **P1** | Does looking up increase your problem? | | | |
| **E2** | Because of your problem, do you feel frustrated? | | | |
| **F3** | Because of your problem, do you restrict your travel for business or recreation? | | | |
| **P4** | Does walking down the aisle of a supermarket increase your problems? | | | |
| **F5** | Because of your problem, do you have difficulty getting into or out of bed? | | | |
| **F6** | Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties? | | | |
| **F7** | Because of your problem, do you have difficulty reading? | | | |
| **P8** | Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems? | | | |
| **E9** | Because of your problem, are you afraid to leave your home without having someone accompany you? | | | |
| **E10** | Because of your problem have you been embarrassed in front of others? | | | |
| **P11** | Do quick movements of your head increase your problem? | | | |
| **F12** | Because of your problem, do you avoid heights? | | | |
| **P13** | Does turning over in bed increase your problem? | | | |
| **F14** | Because of your problem, is it difficult for you to do strenuous homework or yard work? | | | |
| **E15** | Because of your problem, are you afraid people may think you are intoxicated? | | | |
| **F16** | Because of your problem, is it difficult for you to go for a walk by yourself? | | | |
| **P17** | Does walking down a sidewalk increase your problem? | | | |
| **E18** | Because of your problem, is it difficult for you to concentrate? | | | |
| **F19** | Because of your problem, is it difficult for you to walk around your house in the dark? | | | |
| **E20** | Because of your problem, are you afraid to stay home alone? | | | |
| **E21** | Because of your problem, do you feel handicapped? | | | |
| **E22** | Has the problem placed stress on your relationships with members of your family or friends? | | | |
| **E23** | Because of your problem, are you depressed? | | | |
| **F24** | Does your problem interfere with your job or household responsibilities? | | | |
| **P25** | Does bending over increase your problem? | | | |

| ***FOR OFFICE USE ONLY: Patient ID #: _____*** | | | | | 16-34 pts (mild) |
|---|---|---|---|---|---|
| | **Total Functional (F)** | **Total Emotional (E)** | **Total Physical (P)** | **TOTAL SCORE** | 36-52 pts (moderate) |
| **Evaluation:** | | | | | 54+ pts (severe) |