Adirondack Audiology
Hearing and Balance Centers

VNG Balance Exam

Purpose of the test: Examination and measurement of eye movements (nystagmus) are helpful in the diagnosis and treatment of certain inner ear disorders in patients who complain of dizziness. A VNG will help to determine whether your complaints are related to an abnormality of the balance system in the ear.

What will take place: The test is pain less and non-invasive. Infrared goggles will be placed over your eyes in order to monitor eye movement. You will be asked to report any feeling of dizziness during the testing. A probe will also be placed in your ear with warm to cold air being used in the ear to help facilitate results.

The test takes approximately 1 ½ hours and paperwork takes approximately 20 minutes. This time has been reserved for you and cannot be utilized if you fail to keep your appointment. We request a 24 hour advance notice of cancellation, and if you fail to notify us, you will be billed $250.00. Thank you for your cooperation!

PATIENT INSTRUCTIONS:

You will be asked to refrain from taking certain medications for 48 hours prior to your test date. Certain medications can influence the body's response to the test, giving a false or misleading result. You will find a short list below. ***ALWAYS*** consult your physician before discontinuing any prescribed medication!!

****PLEASE REFRAIN FOR 48 HOURS FROM**:**

Alcohol: Beer, wine, cough medicine. **Analgesics-Narcotics:** Codeine, Demerol, Tylenol with codeine, Percocet, Darvocet **Anti-histamines:** Chlor-Trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Triaminic, Hismanal, Claritin, and over-the-counter cold remedies. **Anti-vertigo medicine:** Antivert, Revert, Meclizine. **Anti-nausea medicine:** Atarax, Dramamine, Compazine, Phenergan, Thorazine, Scopalamine, Transdermal Patches.

*** You may take blood pressure medications, heart medications, thyroid medications, Tylenol, Insulin, Estrogen etc. ALWAYS consult with your physician before discontinuing any prescribed medication!

** You may eat lightly for 12 hours prior to your appointment.

**Please avoid caffeine in beverages such as coffee or soft dinks the day of your appointment.

**Testing may cause sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. If this is not possible, however, try to plan your day to include an extra 15-30 minutes after your test, before leaving the office.

Please Do Not wear eye makeup the day of the test.
Wear comfortable clothing on the day of the test.

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Patient Intake Form

Date:	Patient Name:	Preferred Name:
Patient's DOB: / /	Age:	(circle): Male Female
Patient's Mailing Address:		
Home Telephone#:	Cell Phone#:	
Work Telephone#:		
Email Address:		
Marital Status (circle):	Single Married Separated Divorced Widow	
Spouse's Name:		
Emergency Contact:	Relationship:	
Emergency Contact Telephone#:		
Employment Status (circle):	Full Time Part Time Not Employed Retired	
Name of Employer:		
Occupation:		

Patient Insurance Billing Information:

Name of Primary Care Provider (ex. Dr. John Doe):

Name of Referring Provider:

Primary Insurance Carrier: Member ID#

Subscriber's Name:

Mailing address if different from patient:

Secondary Insurance Carrier: Member ID#

Subscriber's Name: DOB (mm/dd/yyyy):

Mailing address if different from patient:

Third Insurance Carrier: Member ID#

Subscriber's Name: DOB (mm/dd/yyyy):

Mailing address if different from patient:

Patient History

Adirondack Audiology
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Patient Name: _____ Date: _____

DOB: _____ Name of Primary Care Physician: _____

Employer: _____ Occupation: _____

What is your primary concern today: _____

How long have you been aware of this difficulty? _____

Is this difficulty due to a work-related injury/exposure? YES / NO

Do you feel your hearing is changing? YES / NO

- If so, do you feel it has been gradual or sudden? GRADUAL / SUDDEN

Have you seen an Ear, Nose and Throat Physician? YES / NO

- If so, who did you see? _____ When? _____

In which situations do you have difficulty hearing? (circle all that apply)

_____ in quiet television phone at work

in background noise at lectures / worship service / theater

When was your last hearing evaluation? _____

Do you currently wear hearing aids? YES / NO Make / Model: _____

- If yes, are you satisfied with them? YES / NO If no, please explain: _____

On a scale of 0-10, how motivated are you to do something about your communication difficulty?

Not motivated at all 0 1 2 3 4 5 6 7 8 9 10 Highly Motivated

Rank the following in order of importance (1-4), if a hearing aid is recommended for you:

__ Improved hearing in quiet __ Improved hearing in noise __ Expense __ Cosmetics

Do you have a history of any of the following? *If* yes, please explain:

Ringing or noises in your ears?	YES / NO	_____
Dizziness or vertigo?	YES / NO	_____
Fullness / pressure in your ears?	YES / NO	_____
Ear infection or ear pain?	YES / NO	_____
Ruptured ear drum?	YES / NO	_____
Ear Surgery?	YES / NO	_____
Family members with hearing loss?	YES / NO	_____
Taking blood thinners/ aspirin?	YES / NO	_____
Head injury?	YES / NO	_____
Surgery within the past year?	YES / NO	_____
Excessive exposure to loud noise? (military, hunting, power tools, music, etc.)	YES / NO	_____

Are you in good health? YES / NO

- If no, please explain: _____

Do you have a history of any of the following? Please check all that apply:

_ Asthma	_ Head Injury/ TBI	_ Measels	_ Neurological Symptoms
_ Arthritis	_ Heart Disease	_ Meningitis	_ Scarlet Fever
_ Bell's Palsy	_ Thyroid Disease	_ Mumps	_ Sinusitis
_ Chemotherapy	_ High Blood Pressure	_ Parkinson's	_ Tuberculosis
_ Diabetes	_ HIV/AIDS	_ Pneumonia	_ Vision Issues
_ Hepatitis	_ Alzheimer's/Dementia	_ Stroke/TIA	_ Chronic Kidney Disease

Have you used a tobacco product one or more times in the past24 months? YES / NO

- If yes, how often have you used a tobacco product in the past 24 months? _____
- If yes, what type(s) of products have you used (cigarette, cigar, smokeless)? _____

Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? YES / NO

- If yes, are you feeling dizzy today? YES / NO
- If yes, please describe: _____

  Frequency of occurrence: _____
- If yes, is it accompanied by: Hearing loss Ringing or noises in your ear

  Nausea __ Visual disturbances __ Other: _____

Have you fallen within the past 12 months? YES / NO

- If yes, how many falls have you experienced in the 12 months? _____
- If you have fallen, have you been injured? YES / NO

  Please describe your injury: _____

Do you experience visual difficulties or disturbances? YES / NO

- If yes, please describe:

Do you currently take a Vitamin D supplement? YES / NO

Do you currently have a pacemaker? YES / NO

Please list any prescription medications you are currently taking:

Medication	Reason	Dosage	Frequency

What would you like to gain from this evaluation? _____

How did you hear about our facility? _____

Communication Assessment

For the following questions, use the scale, 0 through 10.

0 = I can't hear at all in this situation to

10 = I can hear, and I understand everything in this situation.

1. How would you rate your ability to understand when speaking with another person?

1 2 3 4 5 6 7 8 9 10

2. How would you rate your ability to understand while watching TV and in various types of entertainment? (ex. Movies, plays, concerts etc.).

1 2 3 4 5 6 7 8 9 10

3. How would you rate your ability to understand when conversing with a small group of people? (with family, co-workers, in meetings or over dinner).

1 2 3 4 5 6 7 8 9 10

4. How would you rate your ability to understand when you are in an unfavorable listening environment? (ex. noisy party with background music, riding in a car)

1 2 3 4 5 6 7 8 9 10

5. How would you rate your ability to understand, when on a land line telephone?

1 2 3 4 5 6 7 8 9 10

6. How would you rate your ability to understand on a cell phone?

1 2 3 4 5 6 7 8 9 10

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TINNITUS HANDICAP IN VENTORY (THI)

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus . Please ar.iswer every question.-Pleasedo not skip any questions.

Name: Date:

1.	Because of your tinnitus. is it difficult for you to concentrate?	O Yes	O Sometimes	O No
2.	Does the loudnessof your tinnitus make it difficult for you to hear people?	O Yes	O Sometimes	O No
3.	Does your tinnitus make you angry?	O Yes	O Sometimes	O No
4.	Does your tinnitus make you feel confused?	O Yes	O Sometimes	O No
5.	Because of your tinnitus, do you feel desperate?	O Yes	O Sometimes	O No
6.	Do you complain a great deal about your tinnitus?	O Yes	O Sometimes	O No
7.	Because of your tinnitus, do you have trouble falling asleep at night?	O Yes	O Sometimes	O No
8.	Do you feel as though you cannot escape your tinnitus?	O Yes	O Sometimes	O No
9.	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner,to the movies)?	O Yes	O Sometimes	O No
10.	Because of your tinnitus, do you feel frustrated?	O Yes	O Sometimes	O No
11.	Because of your tinnitus, do you feel that you have a terrible disease?	O Yes	O Sometimes	O No
12.	Does your tinnitus make it difficult for you to enjoy life?	O Yes	O Sometimes	O No
13.	Does your tinnitus interfere with your job or household responsibilities?	O Yes	O Sometimes	O No
14.	Because of your tinnitus, do you find that you are often irritable?	O Yes	O Sometimes	O No
15.	Because of your tinnitus, is it difficult for you to read?	O Yes	O Sometimes	O No
16.	Does your tinn itus make you upset?	O Yes	O Sometimes	O No
17.	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and/or friends?	O Yes	O Sometimes	O No
18.	Do you find it difficult to focus your attention away from your tinnitus and on other things?	O Yes	O Sometimes	O No
19.	Do you feel that you have no control over your tinnitus?	O Yes	O Sometimes	O No
20.	Because of your tinnitus, do you often feel tired?	O Yes	O Sometimes	O No
21.	Because of your tinnitus, do you feel depressed?	O Yes	O Sometimes	O No
22.	Does your tinnitus make you feel anxious?	O Yes	O Sometimes	O No
23.	Do you feel that you can no longer cope with your tinnitus?	O Yes	O Sometimes	O No
24.	Does your tinnitus get worse when you are under stress?	O Yes	O Sometimes	O No
25.	Does your tinnitus make you feel insecure?	O Yes	O Sometimes	O No

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DIZZINESS HANDICAP INVENTORY

Name: _____ Date: _____

Part I

Instructions: The purpose this scale is to identify difficulties that you maybe experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes" or "no" or "sometime" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing or to parties?	Yes	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others?	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes
F14. Because of your problem, id it difficult for you to do strenuous housework or yard work?	Yes	No	Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	Yes	No	Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	No	Sometimes
P17. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes
F19. Because of your problem, is it difficult for your to walk around the house in the dark?	Yes	No	Sometimes

E20. Because of your problem, are you afraid to stay home alone?	Yes	No	Sometimes
E21. Because of your problem, do you feel handicapped?	Yes	No	Sometimes
E22. Has your problem placed stress on your relationships with members of your family or friends?	Yes	No	Sometimes
E23. Because of your problem, are you depressed?	Yes	No	Sometimes
F24. Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
P25. Does bending over increase you problem?	Yes	No	Sometimes

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Part II

Instructions: Put a check in the box that best describes you.

	Negligible symptoms (0)
	Bothersome symptoms (1)
	Performs usual work duties but symptoms interfere with outside activities (2)
	Symptoms disrupt performance of both usual work duties and outside activities (3)
	Currently on medical leave or had to change jobs because of symptoms (4)
	Unable to work for over one year or established permanent disability with compensation payments (5)

STOP HERE

YES **Sometimes** **NO**

P(7) _____**X4=**_____ + _____**X2=**_____ + _____**X0=**_____ **Physical Items**_____ **(28)**

E(9) _____**X4=**_____ + _____**X2=**_____ + _____**X0=**_____ **Emotional Items**_____ **(36)**

F(9) _____**X4=**_____ + _____**X2=**_____ + _____**X0=**_____ **Physical Items**_____ **(36)**

Total _____

(max 100 pts)

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Billing Authorization Form

I authorize use of Adirondack Audiology's billing documents on all my insurance submissions, release of information to all insurance companies and payment directly to Adirondack Audiology Associates. I understand that I am responsible for services received from this provider and I do permit a copy of this authorization to be used in place of the original. I authorize any holder of medical or other information about this patient to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information for this or related Medicare claim. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying any treatments (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides for penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Print Patient Name:_____

Signature of Patient:_____ Date: _____

If patient is under 18 years of age:

Print Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____ Date:_____

Consent for Use and Disclosure of Protected Health Information
Notice of Privacy Practices

I hereby give my consent to Adirondack Audiology Associates, P.C. to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices, prior to signing this consent. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action regarding my care.

Adirondack Audiology Associates, P.C. reserves the right to revise its Privacy Notice Policy at any time. A revised copy may be obtained upon request.

I have the right to request that Adirondack Audiology Associates, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I _____ DOB: _____ acknowledge:
Patient Name (Please Print) (MM/DD/YY)

I have received a current copy of the Notice of Privacy Practices provided by Adirondack Audiology Associates, P.C.

I give my consent to allow Adirondack Audiology Associates, P.C. to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

As the patient, please list below the names and relationship of family members, friends or caregivers, who have your permission to discuss your medical history and test results. If the patient is a child under the age of 18 years of age, a parent or legal guardian signature is required.

1._____ (relationship)_____ Telephone#_____

2. _____ (relationship)_____Telephone#_____

Signature of Patient_____ Date:_____

Patient under 18 years of age:
Parent/Legal Guardian Name (Please Print):_____

Consent to Treat Minor

In the case of a patient being a minor (under the age of 18 years). I hereby give consent to provide diagnostic testing and treatment to the patient. I understand that diagnostic testing and treatment of the patient will be limited to the scope of this practice.

Parent/Legal Guardian Signature: _____ Date:_____

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HIPAA Statement
NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our mission is to deliver:

- Effective analysis and diagnosis of your hearing loss or balance condition
- Customized technology solutions that effectively integrate speech comprehension back into your life
- Unsurpassed patient satisfaction
- Excellence through continuing education
- Ongoing investment in the most advanced processes, procedures and technology to ensure superior results for each patient

Our practitioners understand "value" is not measured by price alone. Rather, value is about how well they utilize their knowledge and experience to create a customized solution to meet your hearing expectations and your lifestyle.

According to HIPAA regulations, you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

- Treatment is the provision, coordination or management of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing health care. For example, we may need to give your health plan information about treatment you received at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Keith Walsh, Au.D.
Owner
10 Marsett Road, Suite 3
Shelburne, VT 05482
Telephone#: 802-922-9545

If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice
2. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained
3. We reserve the right to make an important change in our privacy practices and change this notice to that effect. You may contact us to request a new copy of our notice and we will make the new notice available upon request.

The following is a description of the different circumstances that may require our practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits
3. Provide treatment communications concerning treatment alternatives or other health related products or services, unless we or a business associate receive financial remuneration in exchange for the communication in which case we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.
4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations
5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities
6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability
7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
8. Medical information may be disclosed when necessary to comply with Workers' Compensation.
9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.
11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You

have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.

12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.
13. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
14. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your health care.

You have individual rights as part of the Notice of Privacy Practices. As a patient of our practice you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limits to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.
4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the front office staff.
5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to our practice.
6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, health care operations and/or other specified exception.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to our practice.