Ascent
AUDIOLOGY & HEARING

Patient Registration Form

Patient Name: _____

Gender: Male / Female / Other

Street Address, City, State, Zip Code: _____

_____

Date of Birth: _____ **Social Security Number:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone #: _____

E-mail Address: _____ **Spoken Language:** English Spanish Other

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse:** _____

Employer: _____ Part/Full/Retired **Occupation:**_____

Emergency Contact: _____

Relationship to Patient:_____ **Phone #:**_____

Referring Physician Name: _____ **Phone #**_____

Primary Care Physician Name: _____ **Phone #**_____

Other:_____ **Phone #**_____

Do you give us permission to send Results to your Referring and/or Primary Care Physician/Other: Yes / No

Insurance Information

Primary Insurance:_____ **Member ID:**_____

Guarantor/Responsible Party/Name of Insured (if different than above): _____

DOB of Insured: _____ **Social Security Number of Insured:** _____

Secondary Insurance:_____ **Member ID:**_____

Guarantor/Responsible Party/Name of Insured (if different than above): _____

D.O.B of Insured:_____ **Social Security Number of Insured:**_____

Address of Guarantor/Responsible Party/ Name of Insured, (if different): _____

(*Former or Present Military - Please provide Sponsors Name, Date of birth and Social Security # ****)***

_____

WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

Please Let us known how you heard about us?_____

_____

_____ **(initial here) By initialing this section and signing below, I agree to allow ASCENT AUDIOLOGY to provide me with evaluation and treatment services. I understand that I may revoke this authorization at any time.**

_____ **(initial here) By initialing this section and signing below, I acknowledge that I received a copy of the ASCENT AUDIOLOGY Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, or by request and that any revised Notice of Privacy Practices will be made available upon request.**

_____ **(initial here) By initialing this section and signing below, I agree to accept the financial policies of ASCENT AUDIOLOGY. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services. Although we will gladly bill your insurance when possible, <u>you will be responsible for any unpaid balance by your insurance</u>.**

Signature of Patient or Guardian: _____Date:_____

<u>Adult Case History Form</u>

Please check <u>all</u> medical conditions that apply:

_____**Developmental disorder/delay,** *If checked*, please explain:_____

_____**Dizziness or Unsteadiness,** *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____**Ear Deformity,** *If checked, Right ear Left Ear Both ears*

_____**Ear Drainage,** *If checked, Right ear Left Ear Both ears*

_____**Ear Pain,** *If checked, Right ear Left Ear Both ears*

_____**Family History of Hearing Loss,** *If checked, who?* _____

_____**History of Ear Infections,** *If checked, Right ear Left Ear Both ears*

If so, when? _____

_____**History of Falling,** *If checked, have you fallen two of more times in the past year or been injured?*

_____

_____**History of Noise Exposure,** *If checked, please describe?* _____

_____**Previous Ear Surgery,** *If checked, Right ear Left Ear Both ears If so, when?* _____

_____**Tinnitus/Ringing/Noises in ears,** *If checked, Right ear Left Ear Both ears Frequency?* _____

_____**Tobacco Uses,** *If checked, what type of tobacco products?* _____

Adult Case History Form

Have you experienced any of the following major medical conditions (please check all that apply):

☐AIDS/HIV	☐Arthritis	☐Blood Disorders	☐Cancer
☐Chicken Pox	☐Depression	☐Diabetes	☐Diphtheria
☐Encephalitis	☐Fatigue	☐Genetic Disorders	☐Headaches
☐Head Injury	☐Heart Problems	☐High Blood Pressure	☐High Fevers
☐Influenza	☐Malaise	☐Malaria	☐Measles
☐Meningitis	☐Mumps	☐Scarlet Fever	☐Stroke
☐TMJ	☐Typhoid	☐Vascular Problems	☐Other:_____

Current Medications (please list drug name, dosage, frequency and route into body):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Have you been immunized? **Yes / No**

If yes, for what illnesses or diseases: _____

Please check all medical symptoms or conditions that apply:

- Eye problems (such as blurred or double vision, pain): **Yes / No**
- Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues): **Yes / No**
- Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations): **Yes / No**
- Respiratory issues (such as shortness of breath, cough, wheezing): **Yes / No**
- Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain): **Yes / No**
- Musculoskeletal issues (such as joint pain, swelling, recent trauma): **Yes / No**
- Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness): **Yes / No**
- Psychiatric issues (such as depression, anxiety, compulsions): **Yes / No**
- Endocrine symptoms (such as frequent urination, hot flashes): **Yes / No**
- Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands): **Yes / No**
- Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency): **Yes / No**

Comments related to Review of Symptoms above: _____

Audiologic History

Patient Name: _____ Date of Birth:_____

Do you experience hearing loss? **Yes / No (If No, Please Skip this Page)**

If so, which ear? **Right Left Both**

If you experience hearing loss, which best describes it? **Gradual Fluctuating Sudden**

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing test? **Yes / No**

If so, when: _____

Which ear do you typically use to talk on the telephone: **Right / Left**

Have you ever worn or tried a hearing aid or amplifier? **Right ear Left ear Both ears**

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Hearing Handicap Screening

(please select the most appropriate response):

- Does a hearing problem cause you to feel embarrassed when meeting new people?
  - **Yes No Sometimes**
- Does a hearing problem cause you to feel frustrated when talking to family members?
  - **Yes No Sometimes**
- Do you have difficulty hearing when someone speaks in a whisper?
  - **Yes No Sometimes**
- Do you feel handicapped by a hearing problem? **Yes No Sometimes**
- Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?
  - **Yes No Sometimes**
- Does a hearing problem cause you to attend lectures or religious services less often than you would like?
  - **Yes No Sometimes**
- Does a hearing problem cause you to have arguments with family members? **Yes No Sometimes**
- Does a hearing problem cause you difficulty when listening to TV or radio? **Yes No Sometimes**
- Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
  - **Yes No Sometimes**
- Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?
  - **Yes No Sometimes**

Ascent AUDIOLOGY & HEARING

COVID-19 Screening Questions

	YES	NO
Have you or anyone in your household had any of the following symptoms in the last 14 days? • Fever • Loss of smell / loss of taste • Shortness of breath for unknown reasons • Chills • Sore throat • Cough • Body Aches	❑	❑
Are you currently experiencing any of these stated symptoms?	❑	❑
Have you or anyone in your household been tested positive for COVID-19?	❑	❑
To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVOD-19 within the last 14 days?	❑	❑
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or tested positive for COVID -19 in the last 14 days?	❑	❑
Do you have any reason to believe you or anyone in your household has been exposed or contracted COVID-19 in the last 14 days?	❑	❑
Person protective equipment is required for your examination. Are you willing to wear PPE for the duration of your evaluation?	❑	❑

Ascent AUDIOLOGY & HEARING

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

The HIPAA Privacy Rule

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule

The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- OCR HIPAA Privacy December 3, 2002 Revised April 3, 2003
- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies. The notice must include an effective date.

See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health Plans must also:
    - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
    - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
    - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also:
    - OCR HIPAA Privacy December 3, 2002 Revised April 3, 2003
    - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
    - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
    - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
        - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them and post it in a clear and prominent location at the facility.

A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service 3 OCR HIPAA Privacy December 3, 2002 Revised April 3, 2003 delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Welcome to Ascent Audiology and Hearing

Partnered with The American Institute of Balance

The Institute was founded in 1992 and is among the country's largest multi-specialty centers for the evaluation and treatment of dizziness and balance disorders. The institute is nationally and internationally known for its expertise in evaluation, treatment and rehabilitation. The institute's therapy programs are used by physician, audiologist and therapists worldwide.

What to Expect at your Appointment?

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60 – 90 minutes.

Prior to each test and explanation will be given so 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 you referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions carefully:

1. Do bring your Photo ID, Insurance Card and List of Medications.
2. Do Not wear any makeup, including mascara, eye liner, or face lotions. Those products might interfere with the recordings.
3. Do Not drink alcoholic beverages for 48 hours before the test.
4. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. Anti-Vertigo medicines: anti-vert, Ru-vert, or Meclizine: Anti-nausea medicine: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan, Thorazine, Scopalomine, Transdermal.
5. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be with out them for 48 hours.
6. 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.
7. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include and extra 15 to 30 minutes after your test before leaving the office.

Ascent AUDIOLOGY & HEARING

Patient Questionnaire

PATIENT NAME:_____

DATE:_____

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? _____

1. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

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? Parent Sibling Child
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Have you ever fallen? How many times? _____
		Where? _____ Inside the home Outside the home
☐	☐	Are you afraid of falling?

2. 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 (3).

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section 3.
☐	☐	If in attacks, 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?
		What? _____
☐	☐	Do you know of anything that will make your dizziness worse?
		What? _____
☐	☐	Do you know of anything that will precipitate an attack?
		What? _____
☐	☐	Do you know any possible cause of your dizziness?
		What? _____

© American Institute of Balance 2019

Partners in Balance™ The American Institute of Balance®

The American Institute of Balance

Patient Name: _____

Initial Visit / Follow-up / Discharge

Date: _____

The Dizziness Handicap Inventory (DHI)

PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS		YES	SOMETIMES	NO
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 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?			

Used with permission from GP Jacobson. Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

rev. 05-2019

For Office Use Only
Score P: _____ E: _____ F: _____

16-34 Points (mild)
36-52 Points (moderate)
54+ Points (severe)