Otology / Neurotology

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Emeritus (1924-2001)

Audiology
Julie Hobbs, M.A., CCC-A
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Vestibular Technician

Brian Morin, B.S.

Otologic Surgery

Neurotology

Skull Base Surgery

Vestibular Disorders

Audiology

Hearing Aid Dispensing

Cochlear Implants

Implantable Hearing Aids

Main Office:
6041 Wallace Road Extension
Suite 110
Wexford, PA 15090
(412) 321-2480
FAX (412) 321-3229

Allegheny General Hospital
420 East North Avenue, Suite 402
Pittsburgh, PA 15212

Monroeville Office
Med Health Services Building
200 James Place, Suite 406
Monroeville, PA 15146

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www.pittsburghear.com

Pittsburgh Ear
ASSOCIATES P.C.

Practice limited to the ear,
facial nerve and skull base.

Dear Patient:

We welcome you as a patient and appreciate the opportunity to provide medical care. Enclosed you will find our financial policy and forms which must be completed prior to your arrival in our office.

Our office participates in most major healthcare insurance plans. If a referral is required for your visit, we recommend that you contact your Primary Care Physician (PCP) as soon as possible. If your referral has not been received in our office, you may be asked to reschedule. **Co-Payment is due on the date of service.**

We try our best to maintain an efficient office schedule and to avoid any unnecessary delays or the need to reschedule. We ask for your assistance in the following:

- **Plan to arrive 15 minutes early**
- **Contact your insurance company to verify coverage for your visit**
- **Complete the enclosed forms and bring with you the day of your visit**
- **Bring copies of your medical records/x-ray films or disks if available**
- **Bring your current insurance card**
- **Bring your photo ID (driver's license) or other form of identification**
- **Complete list of all medications taken daily and dosages**
- **Name, address, phone, fax, for your Primary Care Physician and/or referring physician for correspondence**
- **Co-Payment due at the time of service** (we accept cash, check, Mastercard, Visa, Discover, American Express)

We look forward to meeting you on _____

at _____ am pm

_____ Allegheny General _____ Wexford _____ Monroeville

Sincerely,

Douglas A. Chen, M.D.

Todd A. Hillman, M.D.

and Staff

Pittsburgh Ear Associates, P.C.

Patient Information (please print)

Last Name First Name Initial

Patient Street Address

City State Zipcode

Date of Birth

Male _____
Female _____

Patient Social Security Number

If patient is a minor, full name of parent/legal guardian(s):

First Name Last Name

Address (only if different from above)

City State Zipcode

( ) Home Phone

( ) Mobile/Cell Phone

( ) Work Phone

Email

Occupation

Language

Race

Ethnicity

Emergency Contact Person

Name of Contact & Relationship to Patient

Street Address

City State Zipcode

( ) Phone Number

Pharmacy Information

Pharmacy Name

Street Address

City State Zipcode

( ) Phone Number

Referring Physician Information

First Name Last Name

( ) Phone Number

Primary Care Physician Information

First Name Last Name

( ) Phone Number

Insurance Information (Required)

Insurance #1 (Primary Coverage)

_____
Full Name of Insurance Company

_____ _____
Patient Name Date of Birth

_____ _____
Subscriber (Name of person insurance is under) Date of Birth

_____ _____ _____
Relationship to patient Group Number ID Number

Do you have additional insurance coverage? If so, please provide information:
Insurance #2 (Secondary Coverage)

_____
Full Name of Insurance Company

_____ _____
Patient Name Date of Birth

_____ _____
Subscriber (Name of person insurance is under) Date of Birth

_____ _____ _____
Relationship to patient Group Number ID Number

Accident Information:

Is your visit due to an accident? _____ Date of Accident: _____

Circle One: Work Auto Other: _____
(please explain)

Work Related Accident / Auto Accident - Please Complete

_____ (_____)_____
Employer Name or Insurance Company Name Phone Number

_____ _____
Address Claim Number

_____ _____
City State Zipcode Case Manager or Contact Person

GUARANTEE OF PERSON RESPONSIBLE FOR PAYMENT:

Patient Name: _____ I, the undersigned, hereby gurantee payment of charges for the above named patient.

Signature: X _____ Witness: X _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment directly to the above named of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due according to the office's regular charges for services provided. I understand that I am financially responsible for charges not covered by this authorization.

X _____
Signature of Policyholder or Representative

MEDICARE SIGNATURE CARD:

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN):
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries of carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physican or organization furnishing the service or authorize such physician to submit a claim to Medicare for payment to me.

X _____ Date: _____
Signature

MEDICAID: Statement to permit payment or Medicaid benefits to Physician / Provider.
I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare or its intermediaries or carriers any information needed for this or related Medicaid claim. I request that payment of services to the physician furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

X _____ Date: _____
Signature

CONSENT TO RELEASE INFORMATION:
I hereby request and authorize Pittsburgh Ear Associates to contact my insurance company or provide my insurance company information that may be necessary for the company to process my medical claims. The information to be released will include my medical statusor proposed treatment.

X _____ Date: _____
Signature

X _____
Witness

PLEASE PRESENT YOUR INSURANCE CARDS TO RECEPTIONIST

Please present your insurance cards to Receptionist

Pittsburgh Ear Associates, P.C.
420 East North Avenue Suite 402
Pittsburgh, PA 15212
412-321-2480

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I will be provided with a copy of Pittsburgh Ear Associates P.C. (the "practice") Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the **Health Insurances Portability and Accountability Act of 1996, (HIPPA)** that may be made by the Practice and of my rights and the Practice's legal duties with respect to my protected health information. ***I will have the opportunity to review the Notice and take a copy with me if I so choose.***

_____

Patient's Name (Print)

_____

Patient's Signature

_____

Date

Patient Permission to Discuss Protected Healthcare Information

I, _____ hereby request to appoint a family member or friend to act on my behalf in discussing health information with my physician/audiologist or designated medical personnel at Pittsburgh Ear Associates.

_____ _____

Name of Family Member/Friend Relationship to Patient

_____ _____

Address Phone Number

_____

City State Zip code

Are there any limitation on issues your personal representative may discuss _____ no _____yes

_____

List Limitations

Do we have permission to leave a phone message regarding your test results with the following?:

_____ Answering machine _____ Voice Mail _____ Family Member _____ Cell Phone

_____ Only Myself (Check All That Apply) Cell Phone #: _____

Pittsburgh Ear Associates, P.C.
420 East North Avenue Suite 402
Pittsburgh, PA 15212
412-321-2480

OUR FINANCIAL POLICY

1. Payment is due at the time of service unless arrangements have been made in advance with our office. We accept Visa, Discover, MasterCard, and American Express.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your claim if you assign the benefits to the doctor—in other words if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and **you are required to pay your co-payment at the time of your visit.**

4. If you are insured by a plan that we do not participate with, you are responsible for payment to us when services are rendered. We do not file claims for any non-par insurance plans.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be **"non covered", you will be responsible for the complete charge**. Payment is due at the time of service.

6. If you have a high deductible insurance plan, and you have not met the deductible for your policy period, payment is due at the time of your office visit or prior to your scheduled surgical procedure. Arrangements for payment will be made with you in advance once your benefits have been determined.

I have read and understand the practice financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if a minor) Date

PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF YOUR APPOINTMENT

Date: _____ Name:_____ Age:_____

Current Medications:

Allergies to Medications:

Previous Surgery:

REVIEW OF SYSTEMS

AT THIS TIME DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:

Constitutional

Yes	No	fever or chills
Yes	No	weakness or fatigue
Yes	No	recent weight loss

Eyes

Yes	No	blurred vision
Yes	No	double vision

Ears, Nose, Mouth, and Throat

Yes	No	trouble hearing
Yes	No	tinnitus, noise or ringing in the ears
Yes	No	ear pain
Yes	No	ear infection or drainage
Yes	No	dizziness, vertigo, or unsteadiness
Yes	No	stuffy nose
Yes	No	frequent colds
Yes	No	hay fever
Yes	No	sinus trouble
Yes	No	frequent nosebleeds
Yes	No	frequent sore throats
Yes	No	pain near teeth or mouth
Yes	No	hoarseness or voice change
Yes	No	difficulty with swallowing
Yes	No	lumps in neck
Yes	No	swollen glands in neck
Yes	No	pains in the neck

Cardiovascular

Yes	No	heart trouble
Yes	No	palpitations
Yes	No	high blood pressure

Respiratory

Yes	No	cough
Yes	No	asthma or wheezing
Yes	No	shortness of breath

Gastrointestinal

Yes	No	heartburn or acid reflux
Yes	No	nausea or vomiting
Yes	No	diarrhea
Yes	No	ulcers

Genitourinary

Yes	No	frequent urination
Yes	No	painful urination

Musculoskeletal

Yes	No	joint pain or stiffness

Integumentary

Yes	No	skin rashes
Yes	No	excessive skin dryness/itchiness

Neurological

Yes	No	headaches
Yes	No	numbness in face, arms, or legs
Yes	No	seizures
Yes	No	weakness of arms or legs
Yes	No	blackouts or fainting
Yes	No	trouble speaking
Yes	No	confusion or memory loss

Psychiatric

Yes	No	nervousness or increased stress
Yes	No	sleep problem
Yes	No	excessive moodiness or worry

Endocrine

Yes	No	heat or cold intolerance
Yes	No	excessive thirst or urination

Hematologic

Yes	No	easy bruising or bleeding
Yes	No	anemia

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Allergic

Yes	No	hay fever or dust/mold allergy
Yes	No	food sensitivity or intolerance
Yes	No	chemical sensitivity

Past Medical History

DO YOU HAVE, OR HAVE YOU EVER HAD.....

Yes	No	Heart Disease (heart attack, angina, heart surgery, arrhythmia)
Yes	No	Diabetes
Yes	No	Lung Disease
Yes	No	High Blood Pressure
Yes	No	Thyroid Problems
Yes	No	Kidney Problems
Yes	No	Cancer
Yes	No	Liver and Gallbladder Trouble
Yes	No	Head Trauma
Yes	No	Stroke or TIA
Yes	No	Migraine Headaches
Yes	No	Seizure
Yes	No	Anxiety Disorder
Yes	No	Depression
Yes	No	Panic Attacks
Yes	No	Arthritis
Yes	No	Glaucoma
Yes	No	Macular Degeneration
Yes	No	Transfusion of Blood or Blood Products

Social History:

Occupation: Martial Status:

Children:

Yes	No	Do you use tobacco? _____packs/day _____years. Quit, how long ago? _____
Yes	No	Do you use alcohol? _____ drinks/day/ week/ weekend/ month
Yes	No	Do you use coffee, tea or caffeine containing beverages? _____ cups/ day

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IF ANY BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING, PLEASE CIRCLE AND INDICATE WHICH RELATIVE:

Epilepsy	Migraine	Mental Illness	Glaucoma
Diabetes	Thyroid	Anemia	Bleeds Easily
Heart Disease	Stroke	High Blood Pressure	
Cancer	Hearing Loss		

Patient Signature: _____

Reviewed by: _____ **M.D.**

DIZZINESS / IMBLANCE QUESTIONAIRE

Please complete this questionnaire and bring it with you to your appointment.

NAME: _____ DATE: _____ AGE: _____

Please answer these questions about your dizziness/ imbalance. "Dizziness" is a broad term used to define many sensations.

A. When you are "dizzy" do you experience any of the following sensations?

Please read the entire list first. Then circle **Yes** or **No** to describe your feelings most accurately.

Yes No 1. Lightheadedness or swimming sensation in the head
Yes No 2. Blacking out or loss of consciousness
Yes No 3. Tendency to fall: To the right? To the left? Forward? Backward?
Yes No 4. Objects spinning or turning around you
Yes No 5. Sensation that you are turning or spinning inside, with outside objects remaining Stationary
Yes No 6. Loss of balance when walking: Veering to the right? Veering to the left?
Yes No 7. Headache
Yes No 8. Nausea or vomiting
Yes No 9. Pressure in head
Yes No 10. Other, please specify _____

B. Please answer these questions about your dizziness/ imbalance.

Circle **Yes** or **No** and fill in the blank spaces. **Answer all questions**

1. When did the dizziness/ imbalance first occur? _____
2. My dizziness/ imbalance started?

Yes No Suddenly?
Yes No Gradually?

3. My dizziness/ imbalance is:

Yes No Constant?
Yes No In attacks?

4. If in attacks:

How often do they occur? _____
How long do they last? _____
Describe your **first** attack of dizziness _____
_____
_____

Yes No Do you have any warning when the attack is about to start? _____
_____

Yes No Do they occur at any particular time of the day or night? _____
Are you completely free of dizziness between attacks? _____
When was the last attack? _____
Describe your **last** attack _____
_____
_____

5. Overall has your dizziness gotten better or worse since starting? _____
_____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

NAME: _____

Yes No 6. Do any other symptoms occur simultaneously with the dizziness such as nausea, vomiting, ringing in the ears, or ear pressure? Please explain. _____

_____

_____

Yes No 7. Does the dizziness occur only in certain position? If yes, what positions? _____

_____

Yes No 8. Do you have any trouble walking in the dark?

Yes No 9. Does the dizziness occur only while standing or walking?

Yes No 10. When you are dizzy, must you support yourself when standing or walking?

Yes No 11. Do you know any possible cause for your dizziness? What? _____

_____

12. Do you know anything that will:

Yes No Stop your dizziness or make it better? _____

Yes No Make your dizziness worse? _____

Yes No Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional Upset? Headache? Other? _____)

Yes No 13. Were you exposed to any irritating fumes, paints, etc., at the onset of the dizziness?

Yes No 14. Have you ever injured your head or neck? Describe the accident _____

_____

Yes No 15. Have you ever fallen because of the dizziness? How many times? _____

Yes No 16. Are you prone to motion sickness?

Yes No 17. Have you ever been treated with intravenous antibiotics such as Gentamicin, Streptomycin, etc. or chemotherapeutic drugs? If yes, which ones? _____

_____

Yes No 18. Has the dizziness affected the quality of your life?

Yes No 19. Have you ever seen a psychiatrist or psychologist for any reason?

Yes No 20. Are you legally disabled or in the process of determining disability?

C. Please answer these questions about your ears and hearing:

Check **Yes** or **No**, and circle which ear when necessary.

Yes No 1. Do you have difficulty hearing? Right Left Both

2. How long have you noticed the hearing loss?

Right ear _____

Left ear _____

Yes No 3. Do you have any noises in your ears? Right Left Both

Describe the noise _____

Yes No 4. Is the noise constantly with you?

Yes No 5. Does the noise occur only with the dizziness?

Yes No 6. Have you worked in a noisy environment or been exposed to loud noise?

What type of noise exposure?_____

Yes No 7. Do you have pain in your ears? Right Left Both

Yes No 8. Do you have drainage from your ears? Right Left Both

Yes No 9. Do you have fullness of stuffiness in your ears? Right Left Both

Yes No 10. Have you had any surgery on your ears? Right Left Both

Yes No 11. List the date of the surgery, the reason, and the ear operated on _____

_____

Yes No 12. Do any members of your immediate family (parents, brothers, and sisters) have any diseases of the ear or central nervous system (e.g., brain tumors, multiple sclerosis, etc.) If yes, please specify _____

_____