# HEARING & SPEECH CLINIC

303 Williams Ave, Suite 1111
HUNTSVILLE, ALABAMA 35801
Phone (256) 536-7405 • Fax (256) 536-7416
Email: hearclin@aol.com • Website:www.hearingandspeechclinic.com


Patient's Name _____

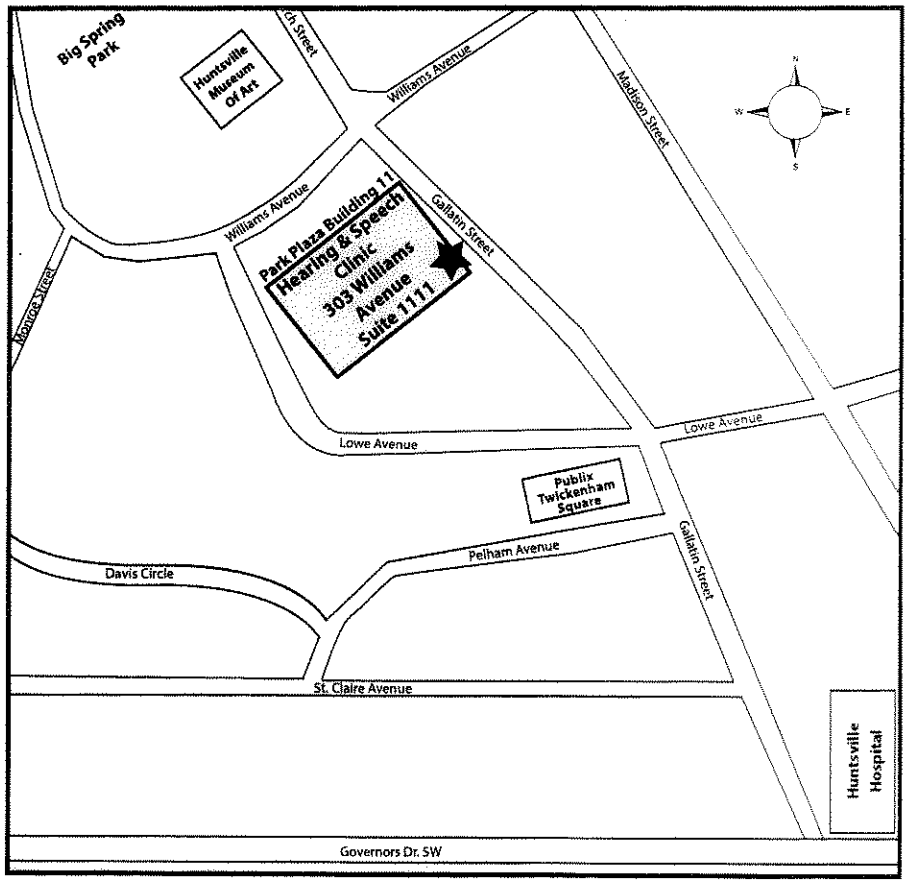
Appt. Date and Time _____

Referred by _____

Please perform the following test(s):

| | | |
|---|---|---|
| Audiogram ☐ | Hearing Aid Eval ☐ | Infant Screening ☐ |
| Tympanometry ☐ | VNG ☐ | ECOG ☐ |
| Real Ear ☐ | ABR ☐ | Other ☐ _____ |

Comments _____




Please fill out the enclosed forms and bring them with you on your appointment date.

Be sure and bring your ID and your insurance cards.

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## VNG INSTRUCTIONS

You have been scheduled for a VNG (Videonystamogram) . This is a test of inner ear function that aids in the diagnosis as to the cause of dizziness and other ear symptoms. This test takes approximately 2 hours. This test is very delicate and influenced by many things. Below is a list of things NOT TO DO prior to coming in:

1. Only those medicines that are absolutely necessary should been taken 48 hours prior to coming in. DO NOT take medications such as:
   - Sleeping pills
   - Tranquilizers
   - Antihistamines
   - Barbiturates
   - Anti-dizzy pills
   - Sedatives
   - Muscle relaxers
   - Anti-depressants

If you have any questions concerning medications, please call our office.

2. No food 4 hours prior to the test.
3. No coffee or cigarettes for 2 hours prior to the test.
4. No makeup.
5. No contact lens.
6. Absolutely no alcohol for 24 hours prior to the test.
7. No strenuous activity for 12 hours prior to the test.
8. Wear comfortable clothing.

The VNG is a simple, painless procedure. The goggles track your eye movement to determine if you have any balance problems related to your inner ear or central nervous system. Small amounts of both cool and warm air will be blown into your outer ear canal. The cooling and warming effect of this air may make you a little dizzy. If it does, it will be over in a minute or two. You may not feel up to driving when the test is completed. Therefore, someone may want to accompany you to the office or be close to a phone in case you need a ride home.

If you have any questions concerning this procedure, please call our office at 256-536-7405.

**IMPORTANT!**

As this test takes at least 2 hours to complete, there will be a $50.00 missed appointment/cancelled fee if this appointment is not cancelled 48 hours prior to the test.

# PATIENT INFORMATION SHEET

**Date**_____

Patient's Name_____
Last First Initial

Street Address_____

City_____ State_____ Zip Code_____ Phone No._____

Date of Birth_____ Age_____Sex_____Married/Single_____ Family Doctor_____

Patient's Social Security No._____-_____-_____ Referring Doctor_____

Email Address_____

How Did You Hear About Us? (Friend, TV ,Newspaper, Direct Mail, or other)_____

Patient's Employer_____Phone No._____

Spouse's Name (Parent's name if child)_____

Address if different from above_____ Phone No._____

Spouse or Parent's Employer_____ Phone No._____

Spouse or Parent's Date of Birth_____ Sex_____ Married/Single_____

Spouse or Parent's Social Security No._____-_____-_____

Primary Insurance Company Name_____Policy Holder's Birthdate_____

Policy Holder's Name_____ Relationship to Patient_____

Secondary Insurance Company Name_____ Policy Holder's Birthdate_____

Policy Holder's Name_____ Relationship to Patient_____

**In case of Emergency Contact**_____ **Phone No.**_____

**I authorize the release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the provider of services for myself and / or dependents. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by the insurance carrier and for services/medical devices not filed with any insurance carrier.**

Date:_____ Signature:_____

Date:_____Signature:_____

Date:_____Signature:_____

Date:_____Signature:_____

Date:_____Signature:_____

Medical Hearing History Date_____

Name_____

1. What is your reason for this visit?

_____

_____

_____

2. Do you have a family history of hearing loss? YES ____ NO____

3. Do you have ringing or other noises in your ears? YES ____ NO ____

4. If yes, is the ringing constant? YES ____ NO ____

5. Do you or have you ever worked around loud noise? YES ____ NO ____

6. Do you have any noisy hobbies? YES ____ NO____

If yes, list.

_____

_____

7. Do you use firearms? YES ____ NO ____

8. Do you use hearing protection in the presence of loud noise? YES ____ NO ____

9. Do you have a history of a head injury? YES ____ NO____

If yes, please describe.

_____

_____

10. Did your hearing problem: progress slowly or was it sudden? SLOWLY ____ SUDDEN____

11. Do you suffer or have you suffered from repeated ear infections? YES ____ NO ____

12. Do you have any fullness or pressure in your ears? YES ____ NO____

13. Have you ever had ear surgery? YES ____ NO____

14. Have you ever worn hearing aids? YES ____ NO____

15. Circle any of the following that apply:

Low birth weight Respiratory problems at birth Measles Mumps
Meningitis Illness with High Fever Rubella Jaundice
Craniofacial Anomalies Cytomegalovirus at Birth (CMV) Diabetes
Kidney Disorders Chemotherapy Ototoxicity Mastoiditis
Mastoid Surgery Heart Attack Otosclerosis Menieres
Stroke Bell's Palsy Cholesteatoma

16. Please list any medications you are now taking._____

_____

_____

**DIZZINESS QUESTIONNAIRE**

**NAME** _____ **DATE** _____

I 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 the head.

II. Please circle yes or no and fill in the blank spaces. Answer all questions.
1. My dizziness is:
YES NO Constant ?
YES NO In attacks?

2. When did the dizziness first occur?_____
3. If in attacks: How often?_____
How long do they last?_____
When was the last attack?_____
YES NO Do you have any warning that the attack is about to start?
Do they occur at any particular time of the day or night?
Are you completely free of dizziness between attacks?
YES NO 4. Does change of position make you dizzy?
YES NO 5. Do you have trouble walking in the dark?
YES NO 6. When you are dizzy, must you support yourself when standing?
YES NO 7. Do you know of any possible causes of your dizziness?
What?_____
8. Do you know of 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?)
YES NO 9. Were you exposed to any irritating fumes, paints, etc.,at the onset of your dizziness?

YES NO 10. If you are allergic to any medications, please list:_____

YES NO 11. If you ever injured your head, were you unconscious?_____

YES NO 12. If you take any medications regularly for any reason, please list:_____

_____

YES NO 13. Do you use tobacco in any form?_____How much ?_____

Do you have any of the following symptoms? Please circle YES or NO and circle ear involved.

YES NO 1. Difficulty in hearing? Both Ears Right Left

YES NO 2 Noise in your ears? Both Ears Right Left

Describe the noise_____

YES NO Does noise change with dizziness?_____If so how?_____

YES NO 3. Fullness or stuffiness in your ears? Both Ears Right Left

YES NO 4. Pain in your ears? Both Ears Right Left

YES NO 5. Discharge from your ears? Both Ears Right Left

YES NO 6. History of loud noise exposure? Both ears

IV. Have you experienced any of the following symptoms? Please circle YES or NO and circle if constant or in episodes

YES NO 1. Double vision, blurred vision or blindness. Constant In Episodes

YES NO 2. Numbness of face Constant In Episodes

YES NO 3. Numbness of arms or legs Constant In Episodes

YES NO 4. Weakness in arms or legs Constant In Episodes

YES NO 5. Clumsiness of arms or legs Constant In Episodes

YES NO 6. Confusion of loss of consciousness Constant In Episodes

YES NO 7. Difficulty with speech Constant In Episodes

YES NO 8. Difficulty swallowing Constant In Episodes

YES NO 9. Pain in the neck or shoulders Constant In Episodes

YES NO 10. Do you have a follow-up visit schedule with your physician?

If yes, when_____

# Patient Record of Disclosure

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). With the right to restrict it's disclosure to family, friends, etc. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individual's office intend of the individual's home.

## I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
## ANSWER ALL THAT APPLY

May we call your home telephone?_____ Phone#_____
May we call your cell Phone?_____ Phone#_____
May we leave a message with detailed information on your answering machine?_____
May we leave message with call back number only?_____
May we leave a message with family?_____
May we contact you at work?_____ Work#_____
May we leave a message with detailed information?_____
May we leave a message with call back number only?_____
May we email you?_____ Email address_____

**Written Communication:**

It is O.K. to fax to this number_____
May we mail information to your home address on file?_____

**You may disclose my PHI to the person or persons listed below:**

_____ relationship _____

_____ relationship _____

Do not disclose my PHI for the following medical conditions:

_____ _____

_____ _____

**Patient's Name** **Date**

The privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use or disclosures made pursuant to an authorization requested to by the individual. Healthcare entities must keep records of Phi disclosures. Information provided on the "Accounting of Disclosures" if completed properly, will be constituted an adequate record. ***Note*** Uses and disclosures for TPO may be permitted without prior consent in an emergency.

# Privacy Practices Acknowledgement

Hearing and Speech Clinic
303 Williams Ave. Ste 1111
Huntsville, Al. 35801

Contact Person: Kathy Jones, Office Manager

## Acknowledgement Form

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Name of Patient: _____
Birthday:_____

Signed:_____
Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate.

Relationship:

_____ parent or guardian of minor patient
_____ guardian or conservator of an incompetent patient
_____ beneficiary or personal representative of deceased patient

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**For Office Use Only:**

**Acknowledgement refused:**

Reason for
refusal:_____

_____

_____

# Hearing Handicap Inventory Screening Questionnaire for Adults

1) Answer **No**, **Sometimes** or **Yes** for each question.

2) Do not skip a question if you avoid a situation because of a hearing problem.

3) If you use a hearing aid, please answer according to the way you hear with the aid.

| | No | Sometimes | Yes | |
|---|---|---|---|---|
| 1. Does a hearing problem cause you to feel embarrassed when you meet new people? | 0 | 2 | 4 | |
| 2. Does a hearing problem cause you to feel frustrated when talking to members of your family? | 0 | 2 | 4 | |
| 3. Do you have difficulty hearing / understanding co-workers, clients or customers? | 0 | 2 | 4 | |
| 4. Do you feel handicapped by a hearing problem? | 0 | 2 | 4 | |
| 5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? | 0 | 2 | 4 | |
| 6. Does a hearing problem cause you difficulty in the movies or in the theater? | 0 | 2 | 4 | |
| 7. Does a hearing problem cause you to have arguments with family members? | 0 | 2 | 4 | |
| 8. Does a hearing problem cause you difficulty when listening to TV or radio? | 0 | 2 | 4 | |
| 9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life? | 0 | 2 | 4 | |
| 10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? | 0 | 2 | 4 | |
| **Totals:** | | | | |

* Adapted from: Ventry, I., Weinstein, B. "Identification of elderly people with hearing problems" American Speech-Language-Hearing Association. 1983, 25, 37-42. *

Interpreting the Raw Score:

0 – 8 = 13% probability of hearing impairment (no handicap)

10 – 24 = 50% probability of hearing impairment (mild-moderate handicap)

26 – 40 = 84% probabililty of hearing impairment (severe handicap)

Name: _____ Date: _____

# NOTICE OF PRIVACY PRACTICES

**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.**
**This notice takes effect on February 26, 2003 and remains in effect until we replace it.**

**Health Record Information:**
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**Our Responsibilities:** We are required to:
Keep your medical information private.
Give you this notice describing our legal duties, privacy practices, with respect to information we collect and maintain about you and your rights regarding your medical information, this is that notice.
Follow the terms of the notice that is now in effect.
We will not use or disclose your health information without your authorization, except as described in this notice.
It is policy of **The Hearing and Speech Clinic** to adhere to the Privacy Rule that retention of medical records for at least six years. We Have the Right to:
Change our private practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
**Notice of Change to Private Practices:**
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.
**Use and Disclosure of Your Medical Information**
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
**For Treatment**: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, audiologists, hearing aid vendors when orders are made, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
**For Payment:** We may use and disclose your medical information for payment purposes to insurance companies in order to pay your claims.
**For Health Care Operations:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.
**Notification:** Medical information to notify; Notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up hearing aids, hearing aid supplies, equipment, or medical information for you.
Disaster relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.
**Fund-raising:** We may provide medical information to one of our affiliated Fund-Raising foundations to contact you for Fund-raising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and dates of your health care. In any Fund-raising materials, we will provide you a description of how you may choose not to receive future Fund-raising communications.

**Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Law enforcement**: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena issued by court.

**Court orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a Court Order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, Fugitive, material witness, crime victim or missing person. We may share the medical information of a person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health**: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect.

**Victims of Abuse, Neglect or Domestic Violence:** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other of other crimes.

**Workers Compensation**: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Your Individual Rights:** You have a right to:

1. Look at or get a copy of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies we will charge you a reasonable fee for each page and postage if you want copies mailed.
2. Receive a list of all the times we, or our business associates, shared your medical information for purposes other than treatment, payment, and health care operations and other specific exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information that you feel is in error. We may deny your request, if we did not create the information you want changed or for other certain reasons.
6. You may request an account of all disclosures of your medical information.

**Questions & Complaints:** If you believe your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing and given to our Security Officer listed at the bottom of the page. You may also file a complaint with the Secretary of The Federal Department of Health & Human Services. We will not retaliate in any way for you filing a complaint.

**Contact person:**

Kathy Jones
303 Williams Ave. Ste 1111
Huntsville, Al. 35801
256-536-7405