BETTERLIVING
AUDIOLOGY

Thank You for Taking the Time to Fill Out This Patient Form Prior to Your Visit.
Please follow the below instructions.

1. **Download the PDF Form**
   Please Note: *Do Not Fill Out the Form Prior to Downloading. The Data Will Not Be Saved.*
2. **Fill Out the Form**
3. **Save PDF as Your Name**
4. **Email Completed Form to frontdesk@betterlivingaudiology.com**

Julie Bier, Au.D. • Corey Enfanto, Au.D.
Doctors of Audiology

54 West Twin Oaks Terrace, Suite 10 • South Burlington, VT 05403 • P: 802-651-9374 • F: 802-651-9376
135-A Creek Rd • Middlebury, VT 05753 • P: 802-989-7210 • F: 802-989-7348

betterlivingaudiology.com

Welcome to Better Living Audiology

Better Living Audiology is Northern Vermont's premier hearing and balance healthcare provider. Our Audiologists are doctors dedicated to providing the highest level of medically-oriented diagnostic and treatment services for individuals with hearing loss, tinnitus, and balance disorders. We provide state-of-the-art technology and truly professional care, according to your priorities.

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, 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.

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 a List of Medications.

2. Do not wear any makeup, including mascara, eye liner, or face lotions. These products may interfere with the recordings.

3. Do not drink caffeinated or alcoholic beverages for 48 hours before the test.

4. Do not use recreational drugs such as marijuana for 48 hours before the test.

5. 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 medicines: Atarax, Dramamine, Compazine, Antiver, Bucladin, Phenergan, Thorazine, Scopalomine.

6. 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 without them for 48 hours.

7. 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.

8. 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 an extra 15-30 minutes after your test before leaving the office.

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Patient Information

(incomplete forms will delay your appointment)

Title: _____ First Name: _____ Middle Name: _____ Last Name: _____

Address:_____ Apt/Unit:_____

City:_____ State:_____ Zip:_____

Date of Birth: ____/____/_____ Gender: _____ Last 4 of Social Security #: ____ ____ ____ ____

Home Phone #: _____ Cell #: _____ E-Mail : _____

Primary Contact: _____ Phone#:_____ Relationship:_____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Primary Doctor:_____ Phone #: _____

Referring Doctor:_____ Phone #: _____

How did you hear about us?_____

The patient/legal guardian authorizes Better Living Audiology staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Better Living Audiology to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and

_____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Better Living Audiology.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation/No Show Policy

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (less than 24 hours) will be charged a $75 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Better Living Audiology's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of Better Living Audiology's Privacy Practices is available to you upon request.

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____ Signature:_____

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Medical History

PATIENT NAME:_____

DATE:_____

Do you have, or have you had, any of the following?

Neurologic

- ☐ Migraine
- ☐ Stroke/TIA
  If so, when? _____
- ☐ Parkinson's Disease
- ☐ Seizures/ Epilepsy
- ☐ Concussion/Head Injury
  If so, when? _____
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic _____

Cardiovascular

- ☐ Heart Attack
  If so, when? _____
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other Cardiovascular_____

Respiratory

- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Other Respiratory _____

Other Health Issues

_____

_____

_____

_____

_____

Orthopedic

- ☐ Artificial Joints
  If yes, which? _____
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
  If so, when? _____
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Orthopedic_____

Vision

- ☐ Cataracts
  If removed, when? _____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision_____

Other

- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Tobacco Use
  If yes, how much? _____
- ☐ Alcohol Use
  If yes, how much? _____

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Medical History

PATIENT NAME:_____

DATE:_____

Please list all of your current medications and supplements

Presciption	Dosage	Frequency	Route	Reason

Over the Counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

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Dizziness Handicap Inventory (DHI)

Initial Visit / Follow-up / Discharge

PATIENT NAME:_____ DATE:_____

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

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

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

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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? _____

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Patient Questionnaire

PATIENT NAME:_____ DATE:_____

3. 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?

4. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle 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? Tingling around the mouth?	☐ Constant	☐ In Episodes
☐	☐	Difficulty speaking?	☐ Constant	☐ In Episodes

5. Do you have any of the following? Please check the box for either YES or NO and circle the ear 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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Advance Beneficiary Notice (ABN)
Non-Medicare

Patient Name: _____ Insurance ID# _____

Note: You need to make a choice about receiving these health care items or services.

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your health cares costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. **There may be a good reason your doctor recommended it. Right now, in your case, your Insurance Company probably will not pay for**:

Item or Service:	92519, 92518, 92517: VEMP Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)
Because:	Investigational

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your Insurance Company probably will not pay.
- Ask us how much these items or services will cost you *(Estimated Cost:* $ 110-200)

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

☐ **Option 1: Yes, I want to receive these items or services.**
I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

☐ **Option 2: No, I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____

SIGNATURE of patient or person acting on patient's behalf **DATE**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.