FREEDOM Hearing Center LLC

Waldorf Diagnostic Hearing & Balance Center
3475 Leonardtown Road, Suite 102, Waldorf, MD
(P) (443) 295-7100 (F) (301) 374-8432
www.freedomhearing.com

Pre-Test Instructions for Videonystagmography (VNG)

You were referred to our clinic because you have spoken to your doctor about your symptoms of dizziness, lightheadedness, and/or unsteadiness. A VNG is a test that focuses on your dizziness/vertigo that can be caused by a disturbance in a particular part of your inner ear of balance system. This test is not painful, however it is time consuming (approximately 1 to 1 ½ hours), so please be prompt.

You must have a driver to escort you to and from this appointment as dizziness, lightheadedness, nausea, and vertigo have been reported by some patients as lingering effects of the vestibular testing. Without a driver you will not be able to complete testing unless you sign our VNG Escort Waiver.

Please be sure to eat a light breakfast/lunch prior to your testing time. Please follow the instructions below. Failure to follow the instructions can cause your test to be inconclusive and/or inaccurate.

1. **DO NOT** wear any make-up the day of your test. This includes **eyelash extensions**, eye shadow, eye liner, mascara, and foundation/powder.
2. **DO NOT** take any of the following at least 48 hours (preferable 72 hours) before the test:
   - Anti-nausea medications: Dramamine, Campazine, Bonine, Marezine, Vontrol, Phenergan, Thorazine, etc…
   - Anti-vertigo medications: Meclizine, Antivert, Ru-vert, etc…
   - Tranquilizers: Valium, Librium, Atarax, Vistrail, Equanil, Miltown, Traivil, Serax, Strafon, etc….
   - Sedatives: Nembural, Seconal, Delmane, Doriden, Placidyl, Quaalude, Butisol, or any other sleeping pill
   - Narcotics and Barbiturates: Pheobarbital, Codeine, Demerol, Dilaudid Percodan, Phenaphen, etc…
   - Anti-Histamines: Chlor-trimeton, Dimetane, Disphorol, Benadryl, Actified, Teldrin, Triaminid, Drixerol, Dimetapp, and/or any over the counter remedies
   - Alcohol: any quantity, including beer, wine, and cough medicines containing alcohol
3. **DO NOT** drink any caffeinated beverages (coffee, tea, colas, cocoa, etc…) for at least 8 hours prior to testing.
4. **DO NOT** smoke for at least 8 hours prior to testing

If you have any questions, please feel free to contact us at 443-295-7100.

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Date:________________________

No Show/Cancellation Policy for VNG Appointments

At Freedom Hearing Center, our goal is to provide quality audiological care in a timely manner. We have implemented a no show/cancellation policy for vestibular appointments, which enables us to better utilize the 90 minutes reserved for vestibular testing.

Cancellation of Appointments

Please be courteous and call our office promptly if you are unable to make your appointment. This time will be reallocated to someone who needs treatment.

If it is necessary to cancel your scheduled office appointment, **we require a 48-hour notice**. Vestibular appointments are in high demand and your early cancellation will give us the opportunity to provide services to another patient in need.

No Show

A “no-show” is someone who misses an appointment without canceling 48 hours in advance. No-shows not only inconvenience our staff, but they also inconvenience other patients in need of audiological care. Failure to arrive at the time of a scheduled appointment will be considered “no-show”.

No shows and cancellations with less than a 48 hour notice will receive an invoice for $150 to cover office time. This fee is the patient’s responsibility, NO insurance will be filed.

______________________________ ______________________________
Signature Printed Name

FREEDOM Hearing Center LLC

Patient Intake Form

PATIENT INFORMATION

Last Name: _______________________________ First Name: _________________________ MI: _________

Address: ____

City, State and Zip: __________________________________ Date of Birth: _______________________________________

Home Phone: ______________________________________ Cell Phone: ____

Work Phone: ____ Email Address: ______________________________________

Emergency Contact/Relationship: ______________________________________ Phone: ______________________________

Sex: Male [ ] Female [ ]
Employment status: Full Time [ ] Part Time [ ] Unemployed [ ] Student [ ] Retired [ ]
Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Domestic Partner [ ]

Other than yourself, with who else can we share/discuss results? ____

Referring Physician: __________________________________ **Primary Physician**: ______________________________________

I would like my written report to be sent to the following physicians: ____

INSURANCE INFORMATION

Primary Insurance:
Plan Name: ___________________________ Policy/ID#____________________________ Group# ____________________
Subscriber's Name: _____________________________ Patient Relationship to Subscriber: _______________________________
Subscriber's DOB: ______________________________ Subscriber's Employer: ____

Secondary Insurance:
Plan Name: ___________________________ Policy/ID#____________________________ Group# ____________________
Subscriber's Name: _____________________________ Patient Relationship to Subscriber: _______________________________
Subscriber's DOB: ______________________________ Subscriber's Employer: ____
If you have a third insurance carrier, please let us know

Many insurance carriers require referral from your Primary Care Physician before you receive care from a specialist; **IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL OR PRIOR AUTHORIZATION IF YOUR MEDICAL COVERAGE REQUIRES IT**.

Person responsible for payment for services rendered by Freedom Hearing Center
Guarantor Name: ____
Address: ____ Phone: ____________________________________
City, State, and Zip: ____

If the patient is a minor, who is/are the legal guardian(s)? ____
I certify that the information I have reported on this form is correct to the best of my knowledge. I understand that if any changes are made to the information above that I notify Freedom Hearing Center. I authorize Freedom Hearing Center to disclose any necessary health information needed for treatment and or payment of services received. I also authorize release of health care information to other health care providers for continuing care and treatment. Lastly, I authorize Freedom Hearing Center to collect any payment made by insurance carrier for services rendered and billed by Freedom Hearing Center. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. **I understand that nothing herein relieves me of the responsibility and obligation to pay for medical services provided and items purchased when a statement is rendered. Delinquent accounts incur collection, court, and attorney expenses.**

____ _____________________________________
Signature of Patient or Guardian Date

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Patient's Name: ______________________ **Today's Date:** ______________________

Family Doctor: ______________________ **Referring Doctor:** ______________________

Address: ______________________ **Address:** ______________________

______________________ ______________________

Phone Number: ______________________ **Phone Number:** ______________________

1. What is the reason for today's visit? ______________________
2. Will this be your first hearing test? [ ] Yes [ ] No
   a. If no, when did you have your hearing tested? ______________________
3. Have you ever had ear surgery? [ ] Yes [ ] No
   a. If yes, explain: ______________________
4. Do you have any of the following:
   a. [ ] Deformity of the ear [ ] Recent ear drainage [ ] Ear infection
5. Do you feel that your hearing is worse in one ear? [ ] Yes [ ] No
   a. If so, which ear is worse? [ ] Left [ ] Right
6. Do you experience noises or sounds in your ears? [ ] Yes [ ] No
   a. If yes, do you experience it in: [ ] Left [ ] Right [ ] Both
7. Have you had sudden or rapid hearing loss in the past 90 days? [ ] Yes [ ] No
8. Have you experienced acute or recurring dizziness? [ ] Yes [ ] No
9. Is there a family history of hearing loss? [ ] Yes [ ] No
   a. If yes, who? ______________________
10. Do you ever have ear pain? [ ] Yes [ ] No
11. Have you been exposed to loud sounds at work or in hobbies? [ ] Yes [ ] No
12. Do you experience sensations of fullness in the ears? [ ] Yes [ ] No
13. Do you have any of the following:

    [ ] High Blood Pressure [ ] Head Trauma [ ] Hypothyroidism [ ] Cancer [ ] Stroke
    [ ] Heart/Vascular Disease Mumps/Measles Meningitis Diabetes

14. Are you on any medications? [ ] Yes (Please list on the back of this sheet) [ ] No
15. Have you every worn a hearing aid? ______________________
16. If you are fortunate enough to be helped, are you prepared today to continue on a program for better hearing, which may include the use of hearing aids? [ ] Yes [ ] No
17. Would anything prevent you from wearing hearing aids?______________________
18. In what situations would you like to hear better?______________________
19. How did you hear about Freedom Hearing? ______________________

Prince Frederick
135 W. Dares Beach Road
Suite 102
Prince Frederick, MD 20678

Solomons
14090 HG Trueman Road
Suite 1400
Solomons, MD 20688

Leonardtown
41660 Courthouse Drive
Suite 301
Leonardtown, MD 20650

Greenbelt
7247 Hanover Parkway
Suite A
Greenbelt, MD 20770

Waldorf
3475 Leonardtown Road
Suite 102
Waldorf, MD 20601

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Name: ____ Date: ________________
Referring Physician: _____________________________
Primary Care Physician: __________________________

Please answer all of the following questions to the best of your ability

Do you experience any of the following sensations (check any that apply):

- ☐ Lightheadedness
- ☐ Swimming sensation in head
- ☐ Blacking out
- ☐ Tendency to fall
- ☐ Loss of consciousness
- ☐ Migraines
- ☐ Nausea/vomiting
- ☐ Objects spinning around you
- ☐ Motion sickness
- ☐ Pressure in head
- ☐ Loss of balance when walking
- ☐ Fear of falling

Please select YES or NO and write your answers

Is your dizziness constant? ☐ Yes ☐ No

How often does your dizziness last? ____

How long do your symptoms last? ____

When did you first experience your symptoms? ____

When was your last episode? ____

Did you ever injure your head? ☐ Yes ☐ No

If yes, please explain

Have you had any recent imaging studies (MRI/CT) completed? ☐ Yes ☐ No

If yes, please explain

Is there any relationship between eating and dizziness? ☐ Yes ☐ No

Can you tell when an attack is about to start? ☐ Yes ☐ No

Do you know of anything that makes your dizziness worse or better? ☐ Yes ☐ No

Worse? ___________________________ Better? ___________________________

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How severe is your dizziness (check any that apply)?

☐ Mild	☐ Moderate	☐ Severe
☐ Getting Better	☐ Getting Worse	☐ Staying the Same

Do you experience any of the following symptoms? Please check box and select the appropriate occurrence.

☐ Double Vision	☐ Constant	☐ In Episodes
☐ Blurred Vision/Blindness	☐ Constant	☐ In Episodes
☐ Numbness in face	☐ Constant	☐ In Episodes
☐ Numbness in arms/legs	☐ Constant	☐ In Episodes
☐ Weakness in arms/legs	☐ Constant	☐ In Episodes
☐ Clumsiness in arms/legs	☐ Constant	☐ In Episodes
☐ Confusion or loss of consciousness	☐ Constant	☐ In Episodes
☐ Difficulty with speech	☐ Constant	☐ In Episodes
☐ Difficulty swallowing	☐ Constant	☐ In Episodes

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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.**

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:
Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment and personal demographics (i.e. address, date of birth, health insurance etc.) This information, often referred to as your health or medical record, serves as basis for planning your care and treatment, and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understanding who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATIONS RIGHTS:
Your health record belongs to you, unless otherwise required by law that it is the physical property of the healthcare practitioner or facility that compiled it. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record, obtain an accounting of the disclosures of your health information, request communications of your health information by alternatives means or alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:
This organization is required to maintain the privacy of your health information. In addition, provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the provisions effective for all protected health information we maintain. Should our information practices change, we will be happy to provide an updated copy upon request as well as provide an updated copy on our website. We will not use or disclose your health information without your authorization, except as described in this notice.

<u>Your health information will be used in the following ways</u>:

1) We will use your health information for treatment. Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your other practitioners with copies of various reports that should assist them in treating you.
2) We will use your health information for payment. A bill may be sent to you, or a third-party payer. The information on/or accompanying the bill may include information that identifies you, your diagnosis, procedures, and supplies used.
3) We will use your health information for regular health operations. Staff members may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used in effort to continually improve the quality and effectiveness of the healthcare and service we provide.
4) We may disclose some of your health information to our Business Associates (i.e. hearing aid manufacturers or earmold labs) so that they can perform the work required. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
5) We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person for your care, your location and/or general condition.

Notice of Privacy Practices

6) We may disclose to a family member, other relatives, or close personal friends, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
7) As required by law, we may disclose to the FDA health information relative to adverse events with respect to product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.
8) We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, such as the Division of Rehabilitative Services.
9) As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury or disability.
10) Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of the other individuals. An inmate does not have the right to the Notice of Privacy Practices.
11) We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provide that a work force member or business associate believe in good faith that we engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
12) We may contact you by telephone, mail, or email to provide appointment reminders, warranty expiration reminders, information about treatment alternatives, other related health information, or services/products that may be of interest to you.

IDENTITY THEFT PREVENTION AND DETECTION

It is the policy of this practice to follow all federal and state laws in protecting your private information and reporting requirements regarding identity theft as per the Red Flag Rules compliance program. To protect your identity Freedom Hearing will ask for the following to protect you:

- Driver's license or other type photo ID
- Current health insurance card
- Utility bill or other correspondence showing current residence if your photo ID does not show a current address

Should Freedom Hearing suspect fraudulent activity (a red flag), Freedom Hearing reserves the right to:

- Cancel the transaction
- Contact the appropriate enforcement
- Notify the affected person
- Notify affected physician(s)

This notice will be maintained on our website and patients will be provided a hard copy upon request.

FOR MORE INFORMAITON, OR TO REPORT A PROBLEM:

If you have questions, and would like additional information, you may contact Freedom Hearing directly at 443-295-7100. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used as outlined in Freedom Hearing Center's **Notice of Privacy Practices**. Specifically, I understand that my PHI will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers (i.e. my insurance company).
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.
- ✓ Provide appointment reminders, warranty expiration reminders, information about treatment alternatives, other related health information, or products/services that may be of interest to me.

I have been informed of your **Notice of Privacy Practices** policy containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time, and that I may contact this organization at any time by telephone or at the address below to obtain a correct copy of the **Notice of Privacy Practices**. I may also find the most recent **Notice of Privacy Practices** online at www.freedomhearing.com.

I understand that I may request verbally or in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Other than yourself, with whom else may we share/discuss results? ____

Patient Name: ____ Date: __________________________________

Signature: ____ Relationship to patient: __________________

*If you have questions, and would like additional information, you may contact Freedom Hearing Center and ask to speak with our HIPAA Privacy Officer, Pamela McIntyre at 443-295-7100.