



VESTIBULAR REGISTRATION FORM
(Please Print)

Today's date:		Email:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr. <input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Nickname):	Birth date: Age: Sex: <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address:		Cell phone no.:	Home phone no.: ()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Primary Care Provider (PCP): Send your reports to PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Mailer <input type="checkbox"/> Family/Friend <input type="checkbox"/> Facebook <input type="checkbox"/> Google/Internet <input type="checkbox"/> Veterans Affairs (VA) <input type="checkbox"/> Other			
Other family members seen here:			

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)	
<p>1. I hereby authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):</p> <p>Name _____ Relationship _____</p> <p>Name _____ Relationship _____</p> <p>Name _____ Relationship _____</p> <p>2. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.</p> <p>3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.</p> <p>4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.</p> <p>5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.</p>	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
Patient/Guardian signature _____		Date _____	



PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

With my consent and signature, Autumn Oak Hearing & Balance may use and disclose protected health information about me to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e., appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me.
3. Mail to my home or other designated address any item (i.e., appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care from me. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me to/with third parties involved in my care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e., dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office Autumn Oak Hearing & Balance, I may revoke this permission; however, Autumn Oak Hearing & Balance may decline to provide further treatment to me. Autumn Oak Hearing & Balance may also decline further treatment to me should my restrictions on the type of third-party information, in the center's opinion, impede medical care of me.

I have the right to review the Notice of Privacy Practice Manual of Autumn Oak Hearing & Balance. Autumn Oak Hearing & Balance may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to my care.

I have the right to request that Autumn Oak Hearing & Balance restrict how it uses or discloses my health information. However, as stated previously, Autumn Oak Hearing & Balance is not required to agree to my restrictions. If Autumn Oak Hearing & Balance accepts my restrictions, Autumn Oak Hearing & Balance is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Autumn Oak Hearing & Balance, in their sole discretion, may decline further treatment for me.

The Federal HIPAA (Privacy Act) of 2001 was created to protect my health information. I understand this must be accomplished within the provisions and rules set up by Autumn Oak Hearing & Balance to fulfill federal law. I may request you to review the manual which spells out these provisions. Autumn Oak Hearing & Balance will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Autumn Oak Hearing & Balance may decline to provide further care. Autumn Oak Hearing & Balance will strive to provide information so that I may make an informed decision concerning the privacy of my medical information.

Patient/Guardian Signature

Date



PATIENT MEDICAL & HEARING HISTORY
(Please Print)

Patient's Name: _____ Date: _____

Why have you decided to have your hearing tested at this time?

- I feel my hearing is poor and may need hearing aids
- Family and friends have suggested that I have my hearing checked
- Other reason: _____

Have you had or currently have any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Chronic Ear Infections |

Have you had any ear surgeries? Yes No

List any ear surgeries and date: _____

Have you had your hearing tested before? Yes No

Estimated Date: _____

Do you feel like you hear better out of one ear versus the other? Yes No

If so, which ear? (Circle One) Left or Right

Have you ever worn hearing aids before? Yes No

Estimated Date for first set: _____

Do you have any vertigo or dizziness? Yes No

Do you have a history of Migraines? Yes No

Estimated Date for most recent Migraine: _____

Have you had any major or minor head injuries? Yes No

Any sudden hearing loss within the last 90 days? Yes No

Any drainage or blood from either ear in the last 90 days? Yes No

Any pain or discomfort in the ear? Yes No

Do you have any ringing, buzzing, or roaring in either ear? Yes No

Any significant wax accumulation? Yes No

Has a doctor removed wax from your ears before? Yes No

Do you have any allergies? Yes No

If so, what are you allergic to?

Do you have any history of noise exposure? Yes No

If so, what type of noise were you exposed to and how long?

Please list any medications that you take. Including over-the-counter products:

Medication: _____



PATIENT CURRENT VESTIBULAR SYSTEM

(Please Print)

Patient's Name: _____ Date: _____

Circle One: Are your symptoms **Dizziness / Imbalance / Both**

Which of the following best describes your symptoms?

- Imbalance
- Falling more often
- World spinning around you
- Other: _____
- You feel as if YOU are spinning; the room is not spinning
- Nausea
- Lightheadedness

When did your symptoms begin? ___/___/___ (estimate if needed)

How long do your symptoms last without stopping?

- Seconds
- Minutes
- Hours
- Days
- Symptoms are constant

Did any of the following occur before your symptoms began?

- Head trauma
- Motor vehicle accident
- Upper respiratory infection
- Change in medication
- Other: _____
- A virus or infection, e.g., Shingles or Cold Sores?
- Surgery
- Stressful event or high stress
- A fall

How many times per **day / week / month / year** (circle one) do you have episodes? _____

Which of the following can provoke, increase, or worsen your dizziness?

- Laying down
- Looking up
- Bending over
- Standing up from bending over
- Turning your head right or left while seated or standing
- Other: _____
- Rolling over in bed
- Standing up from a seated position OR sitting up from a laid position
- Increased stress
- Skipping a meal
- Not drinking enough water

Circle one: Have your symptoms **Improved / Changed / Stayed the Same** since they began?

If improved or changed: How so?

Does anything make your symptoms better?



Which of the following accompanies or occurs immediately prior to an episode of your symptoms?

- Headaches
- Neck Pain
- Hearing Loss: **Right Ear / Left Ear / Both Ears** (circle one)
- Fullness in your ear(s): **Right Ear / Left Ear / Both Ears** (circle one)
- Ringing in your ear(s): **Right Ear / Left Ear / Both Ears** (circle one)
- Simmers or Sparkles in your Vision
- Sensitivity to Light, Sound, Smell (circle all that apply)

Balance and Fall Symptoms

Yes / No: Have you fallen in the past year?

If yes: How many times: _____

If no: Have you experienced “near falls” but you caught yourself?

Yes / No: Are you afraid of falling?

Yes / No: Are you veering/leaning while walking?

If yes: which direction? **Right / Left / Both** (circle one)

Yes / No: Do you have neuropathy, numbness, or tingling in your feet or legs?

Yes / No: Has your exercise decreased?

If yes: Approximately when? ___/___/_____

Yes / No: Orthopedic Injuries?

If yes: Please explain:

Health History

Yes / No: Do you have any known eye/vision issues?

If yes: Please explain: _____

Yes / No: Are you bothered by patterns, screens, or complex visual environments, e.g., supermarkets?

Yes / No: Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

If applicable: Female Hormonal History

Circle one: Are you **Pre- / Peri- / Post-Menopausal**?

Yes / No: Did you have a hysterectomy?

If yes: When? ___/___/_____

Yes / No: Have you had any changes to your contraceptives?

If yes: When? ___/___/_____

Yes / No: Do you currently get hot flashes?

Yes / No: Do you have known hormonal imbalance?

If yes: Are you being treated for this issue?



OUR OFFICE POLICIES

(Please Print)

Patient's Name: _____ Date: _____

Thank you for choosing us as your hearing provider. At Autumn Oak Hearing & Balance, we recommend testing that is based off best practices and not what your insurance policy may or may not cover. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial and office policies, which we require you to read and sign prior to any treatment.

Insurance Benefits

Every insurance plan accepted in our office has different percentages, deductibles, maximums, services covered, and varying fees that the plans will allow. We will do our very best to make as close a calculation as possible of what your insurance will cover, HOWEVER, as we cannot guarantee the calculations or payments from any insurance plans.

We may accept assignment of benefits as a service to you. This means we will file a claim with the insurance company for their estimated portion of coverage. However, we are unable to bill your insurance unless you provide us with your current insurance information. The balance is your responsibility whether your insurance pays or not. Any variations or non-covered services are the patient's responsibility if services are rendered at the date of service.

If we do accept the assignment of benefits from your insurance company, we do require that your account is paid in full within 60 days if your insurance has not paid their portion.

Referrals

If a referral is required by your insurance carrier it is your responsibility to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment should be cancelled, or you are responsible for 100% of the cost of services rendered.

Financial Policies

- Full payment is due at the time of service.
- There is a \$45 service charge for all returned checks. If a check is returned, you will be notified as soon as possible.
- We allow 5 business days for you to bring in payment via cash, credit card or money order.
- If your account goes over 90 days past due, it will be turned over to our collection agency.

Late or Missed Appointments

For our providers to see patients in a timely manner please arrive promptly for your appointment. If you are running late, we ask that you call to inform us as soon as you know you are going to be late. We will let you know if we are able to see you that day or if we need to reschedule your appointment. If you are going to be more than 15 mins late, our office will automatically cancel or reschedule your appointment.

As a courtesy our office will call or text all our patients the day before your appointment for confirmation. **If you miss 2 consecutive appointments with our office any future appointments will be cancelled. In addition, a \$35 charge will be made for each additional canceled or missed appointment unless a 24-hour notice is given.**
(Initials: _____)

Medical Records

Should you need a copy of your medical records, please allow 7-10 business days for completion. Make sure that your Primary Care Provider or any person you may want us to send copies to is written in the **Authorization for Use or Disclosure of Protected Health Information** section of this paperwork.

Patient/Guardian Signature

Date



Use of Artificial Intelligence (AI)

Artificial intelligence (AI) may be lawfully utilized to assist in the recording, transcription, and documentation of patient care interactions, provided such use complies with applicable privacy legislation, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). AI-driven systems can facilitate the accurate capture of clinical conversations, generate real-time transcripts, and automate the integration of pertinent details into electronic health records (EHRs), thereby enhancing both the accuracy and efficiency of clinical documentation. The deployment of such technologies are accompanied by appropriate consent protocols, robust data encryption, and secure storage practices to ensure the confidentiality, integrity, and lawful handling of protected health information (PHI).

Patient/Guardian Signature

Date