



## Patient Intake Information

Hello \_\_\_\_\_,

Your appointment time for VNG testing is: \_\_\_\_\_ at \_\_\_\_\_ at our \_\_\_\_\_ location.

Your appointment time for functional testing is: \_\_\_\_\_ at \_\_\_\_\_ at our \_\_\_\_\_ location.

Two hours have been reserved for each appointment. If you must cancel and/or reschedule, please call 24 hours in advance. Your prompt arrival, 15 minutes prior to the scheduled appointment time, is appreciated. Patients arriving late may need to be rescheduled.

### General Information:

MABI's team of clinicians and staff are pleased to assist you with your balance diagnostic evaluation. All clinicians and staff members are qualified and certified in his/her respective areas of expertise. Our clinicians have many years of medical training in the areas of Audiology and Physical Therapy. Furthermore, each clinician has received additional specialized training in the area of vestibular and balance assessment. The specialized training in the field of balance makes MABI clinicians unique and qualified to evaluate patients in this area of medicine.

### Your testing information:

Below is a brief summary of the testing you should expect as a patient with MABI:

- *Computerized Posturography* is a diagnostic test performed by specially-trained Mid America Balance Institute physical therapists to analyze your bodily systems related to your balance and your motor skills.
- The *VNG test* is a diagnostic test performed by specially-trained MABI audiologists to analyze your balance and how it is affected by your inner ears, vision, and a combination of both. VNG will detect any flaws in your 'vestibular' system, the inner ear system that serves as the body's balance mechanism.

### Medication information:

MABI team members may suggest that you discontinue a certain medication before your audiology and inner ear testing. The Balance Institute can only recommend that you discontinue any medication that may interfere with our testing, but your prescribing doctor should ultimately make this decision.

If this occurs, MABI will instruct you on the specifics regarding discontinuing the medication.

### Final, helpful information:

- MABI works cooperatively inside various SERC Physical Therapy clinics across Kansas City. You are a Balance Institute patient, but you are receiving your test inside of a SERC clinic.

***(Because of this, when you arrive, please inform the front desk that you are a balance patient so the staff can make your experience run smoothly.)***

- Wear comfortable clothing to each test
- Bring your insurance card
- Ladies: do not wear makeup to your inner ear testing. Because eye goggles are used to record eye movement, the audiologist testing you will not be able to get an accurate reading with makeup on the eyes.

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## Patient Information Form

(OFFICE: Upon receiving this form, please immediately fax to MABI at 816-265-6151)

Location: Bel Lib OP Rv      Aud: TK KK KS DW (eval date\_\_\_\_)      PT: DD BD CH JL BM SP (eval date\_\_\_\_)

### General information:

Patient name \_\_\_\_\_ Sex      M      F  
Patient date of birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_      SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Patient address \_\_\_\_\_ Home phone      \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
City, state, zip \_\_\_\_\_ Work/cell phone      \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
\_\_\_\_\_

Emergency contact \_\_\_\_\_ Contact's Phone      \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### Insurance information:

Insurance company \_\_\_\_\_ Co-pay \_\_\_\_\_  
Claim/group number \_\_\_\_\_ Member ID number \_\_\_\_\_

Cardholder name \_\_\_\_\_ Cardholder's date of birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Cardholder's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cardholder's phone      \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Cardholder's employer \_\_\_\_\_ Patient relationship to cardholder \_\_\_\_\_

### Secondary insurance information:

Please provide same pieces of information as above for secondary insurance

### Diagnosis and report information:

Onset date of balance problem \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Referring physician \_\_\_\_\_ Last appt \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Next appt \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Names of physician(s) to whom the Balance Institute should send final report:

\_\_\_\_\_  
\_\_\_\_\_

Patient signature: \_\_\_\_\_ Today's date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_



# History Questionnaire

Date \_\_\_\_\_

Instructions: Even though this form may be lengthy, it is important for the Balance Institute to thoroughly understand your balance concerns.

Patient's name:

Date of Birth:

**INITIAL QUESTIONS:** Please briefly answer these opening questions.

Is your visit to MABI:       Your idea       Your physician's idea       Both

Explain what the physician described regarding your balance disorder:

\_\_\_\_\_

Describe the circumstances and the date in which your balance concerns began. Please describe your initial symptoms.

\_\_\_\_\_

What do you personally think is the cause of your problem?

\_\_\_\_\_

**PROBLEMS:** Have you ever had the following conditions?

Yes	No	Condition	Age at onset	Severity			Yes	No	Condition	Age at onset	Severity		
				Mild	Mod	Sev					Mild	Mod	Sev
		Trouble walking							Giddiness				
		Poor balance							Rocking				
		Falls/near falls							Spinning sensation inside head				
		Spinning sensation							Fear of being in public				
		Linear movement or pulling							Sweating				
		Tilt							Nausea/queasiness/vomiting				
		Lightheadedness/near faint							Double/blurred vision				
		Floating							Flashes of light				
		Swimming sensation							Jumping vision				

**PREVIOUS EVALUATIONS:** Have you received any of the following?

Yes	No	(Check all that apply)	Date	Name of physician	Brief description of results
		Evaluation by ENT (ear, nose, & throat doctor)			
		Evaluation by neurologist			
		MRI or CT Scan			
		Caloric test (water or air in ears)			
		Evaluation by an eye doctor			
		Hearing test			

**PREVIOUS MEDICAL HISTORY: Have you ever had any of the following problems?**

Yes	No	Condition	Date	Yes	No	Condition	Date
		Infection of the ears				Neck pain	
		Difficulty hearing				Arthritis/osteoporosis	
		Pain/fullness/popping/pressure in ear				Loss of consciousness/fainting	
		Pain, numbness, twitching, or weakness in face				Seizures/convulsions	
		Sensation of 'pins and needles' in face				TMJ/pain in jaw/or grinding	
		Crossed eyes/lazy eye				Thyroid disorders	
		Heart problems				Diabetes	
		High cholesterol				High or low blood pressure	

List previous surgeries:

List any previous medical history not mentioned above:

If you have had Syphilis, Meningitis, Lyme Disease, or other infections, please explain the date and prescribed medications for treatment:

**RECENT PROBLEMS: Have you experienced any of the following in the past 12 months?**

Yes	No	Condition	Month began	Severity			Yes	No	Condition	Month began	Severity		
				Mild	Mod	Sev					Mild	Mod	Sev
		Loss of strength							Problems sleeping				
		Loss of energy							Shortness of breath				
		Change in weight							Problems chewing/swallowing				
		Memory loss							Problems speaking				
		Muscle/joint aches							Heart palpitations				
		Lack of coordination							Urinary incontinence				

**TRIGGERS: Do any of the following increase, or bring about your balance problem?**

Yes	No	Condition	Age at onset	Severity			Yes	No	Condition	Age at onset	Severity		
				Mild	Mod	Sev					Mild	Mod	Sev
		Rolling over in bed							Movement of external objects				
		Standing up from sitting							Moving eyes while head is still				
		Rapid head movement							Traveling through tunnel				
		Walking in dark room							Walking down grocery aisle				
		Walking on uneven surfaces (ie: grass in yard)							Spinning or tumbling (ie: theme park rides)				
		Loud noises							Open spaces				
		Coughing or sneezing							Blowing up balloon				

List any trigger(s) not mentioned above that bring about your balance problem and/or dizziness:

Can you bring about your balance problem and/or dizziness voluntarily? Yes  No   
 > If yes, please describe:

**FAMILY/SOCIAL HISTORY: Do you have any family members who have, or previously had, the following problems?**

Yes	No	Condition	Relative(s)	Yes	No	Condition	Relative(s)	Are your parents alive? Yes <input type="checkbox"/> No <input type="checkbox"/>  If your parents' cause of death is related to illness, please describe:
		Meniere's Disease				Cancer or tumors		
		Hearing problems				Stroke		
		Vertigo or dizziness				Heart disease		
		Balance problems				High blood pressure		
		Tremor				Psychiatric disorders		
		Diabetes				Other neurological diseases		
Have you smoked? Yes <input type="checkbox"/> No <input type="checkbox"/> How many years did you smoke? _____ Do you presently smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> How many cigarettes per day? _____ Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> How many drinks per day? _____ Do you drink caffeine? Yes <input type="checkbox"/> No <input type="checkbox"/> How many drinks per day? _____								Have you ever received treatment by a psychiatrist or counselor?  Has your health been affected by depression, anxiety, stress, or phobias?

**HEADACHES: If you have experienced headaches in the past 12 months, please answer the following questions.**

When did these headaches begin?	How often do you have headaches?	How intense is the pain associated with headaches?
Have you recently had multiple headaches that: (please circle)		
Y N Lasted 4 hours or longer	Y N Include pain on one side of the head	
Y N Include a pulsing or throbbing feeling	Y N Associated with nausea or vomiting	
Y N Were aggravated by external light and/or noise	Y N Aggravated by routine physical activity	

**TINNITUS: If you have ever experienced ringing in the ears, please answer the following questions.**

Have you had ringing in the ears? Yes <input type="checkbox"/> No <input type="checkbox"/>  How often in past six months? _____	Where do you experience ringing? (please circle) Left ear      Right ear      Both ears  Describe the sensation (please circle) Steady      Pulsating      High-pitched      Low-pitched
---	--

**EMOTIONAL INVENTORY: With each word, indicate to what extent you generally feel this way.**

(Use the following scale to record your answers.)  
 1 = Very slightly or not at all    2 = Somewhat    3 = Moderate/average    4 = Very often    5 = Always

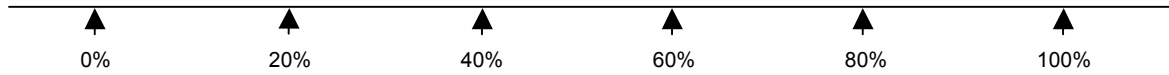
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___ Interested	___ Irritable	___ Active	___ Guilty
___ Distressed	___ Alert	___ Afraid	___ Determined
___ Excited	___ Ashamed	___ Hostile	___ Attentive
___ Upset	___ Inspired	___ Enthusiastic	___ Jittery
___ Strong	___ Nervous	___ Proud	___ Scared

**DIZZINESS INVENTORY:** If you are dizzy, please fill out this page of information. If you are not, please skip.

**Part A: Duration of Dizziness**

In the past six months, what percentage of time would you estimate that your dizziness has interfered with your activities?  
(please mark the appropriate area on the line)



**Part B: Dizziness Impact**

Please answer the following questions about your dizziness and how it affects your life:

Condition	None	Slightly	Moderate	Very moderate	Severe
Rate your level of dizziness at the present moment					
How much has dizziness impacted your ability to work?					
How much has dizziness changed your ability to perform household chores?					
How much does dizziness impact your participation in social activities?					
To what extent does dizziness prevent you from driving?					

Questionnaire completed by: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Reviewed By: (doctor use only)

Initials \_\_\_\_\_

\_\_\_\_\_



## Dizziness Handicap Inventory

*INSTRUCTIONS: The purpose of this form is to identify difficulties you may be experiencing because of your dizziness. Please answer every question.*

1. Does looking up increase your problem?	Yes	Sometimes	No
2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
9. Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
10. Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
13. Does turning over in bed increase your problem?	Yes	Sometimes	No
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
15. Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
22. Has your problem placed stress on your relationship with members of your family or friends?	Yes	Sometimes	No
23. Because of your problem, are you depressed?	Yes	Sometimes	No
24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
25. Does bending over increase your problem?	Yes	Sometimes	No

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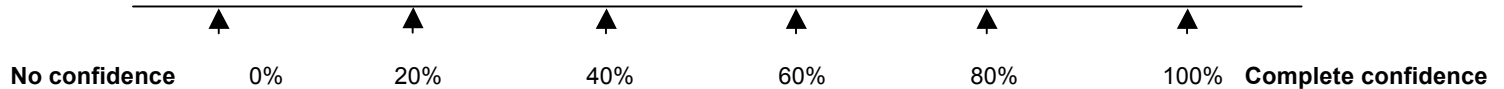
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## Activities Balance Confidence Scale

Indicate your level of confidence performing the activities below without losing balance or becoming unsteady.

If you normally use a walking aid to do the activity, or if you hold onto someone, rate your confidence as if you were using these supports.

Use the percentage scale below:



**How confident are you that you will not lose balance or become unsteady when you:**

1. Walk around the house?

\_\_\_\_\_ %

9. Get into or out of a car?

\_\_\_\_\_ %

2. Walk up or down stairs?

\_\_\_\_\_ %

10. Walk across a parking lot?

\_\_\_\_\_ %

3. Bend over to pick up something from the floor?

\_\_\_\_\_ %

11. Walk up or down a ramp?

\_\_\_\_\_ %

4. Reach for something off a shelf at eye level?

\_\_\_\_\_ %

12. Walk in crowded mall while others walk past you?

\_\_\_\_\_ %

5. Stand on tiptoes to reach for something high?

\_\_\_\_\_ %

13. Are bumped into by other people at the mall?

\_\_\_\_\_ %

6. Stand on a chair and reach for something?

\_\_\_\_\_ %

14. Step on or off an escalator while holding onto railing?

\_\_\_\_\_ %

7. Sweep floor?

\_\_\_\_\_ %

15. Step on or off an escalator while not holding on?

\_\_\_\_\_ %

8. Walk outside the house to a car parked in the driveway?

\_\_\_\_\_ %

16. Walk on snowy and icy surfaces?

\_\_\_\_\_ %

\*Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1995; 50(1): M28-34

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## Medications Interfering with Balance VNG Testing

### IMPORTANT WARNINGS:

- You should first seek approval from your prescribing physician before you stop any of these medications
- If you are unable to contact your physician and be off the medication, please contact the Balance Institute so we can determine if the test results will be valid
- A MABI team member will discuss with you the specifics of any medication on this form you are taking

Acetaminophen/Codeine	Fluphenazine	Remeron
Allegra	Fluvoxamine	Restoril
Alprazolam	Gabapentin	Risperdal
Ambien	Gabitril	Risperidone
Amoxapine	Gen-Xene, Tranxene SD	Ritalin
Amytriptyline + Chlordiazepoxide	Halcion	Robaxin
Anafranil	Hydrocodone + Bitartrate	Roxicet
Antivert	Imipramine	RU-Vert-M
Asendin	Keppra	Sertraline
Ativan	Klonopin	Serax
Aventyl	Levetiracetam	Serentil
Baclofen	Lexapro	Scoplmine
Benadryl	Librax	Sinequan
Bonine	Librium	Skelaxin
Bu Spec	Lioresal	Stelazine
Bupropion HCL	Limbitrol, Limbitrol DS	Surmontil
Buspirone	Lorazepam	Temazepam
Celexa	Lovox	Tigan
Centrax	Mellaril	Thioridazine
Certizine HCL	Meni-D	Thorazine
Chlordiazepoxide	Marazine	Tofranil
Chlorpromazine	Meclizine	Tramadol
Chlorazepate	Mesoridazine Besylate	Tramadol HCL
Citalopram Hydrodomide	Methylcarbamol	Transderm
Clindex	Methylphenidate HCL	Trazodone
Clonazepam	Metaxalone	Tiagabine HCL
Clomipramine	Mirtazapine	Triazolam
Compazine	Neurontin	Trifluoperazine HCL
Cyclobenzaprine HCL	Norpramin	Trimipramine
Dalmane	Nortriptyline	Trimethobenamine
Depakene	Oxycodone	Tylenol 3, Tylenol 4
Depakote	Oxycodone + Acetaminophen	Tylox
Darvon	Oxycodone + Aspirin	Ultracet
Desipramine	Oxycodone + Hydrochloride	Ultram
Desyrel	Oxycontin	Xanax
Diastat	Pamelor	Valium
Diazepam	Paxil	Valproic Acid
Dimetabs	Paroxetine	Venlafaxine
Diphenhydramine	Percocet	Vicodin
Dramamine	Percodan	Vivactil
Doral	Phenergan	Wellbutrin
Doxepin	Prazepam	Zaleplon
Effexor	Prochlorpera	Zolof
Elavil	Promethazine HCL	Zolpedem
Endep	Protriptyline	Zyban
Escitalopram, Oxalate	Proxyphene	Zydone
Fexofenadine	Pulvules	Zyrtec
Flexeril	Oxazepam	
Flurazepam	Quazepam	



## HIPAA and Medical Disclosure

### **HIPAA Overview**

The Mid America Balance Institute believes in safeguarding the privacy and security of your health information and medical records, thus, MABI follows the Health Information Portability and Accountability Act. Passed into law in 1996, *HIPAA* sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies, and anyone else with whom they conduct business. *HIPAA* gives the patient additional rights regarding control and use of health information, giving you more access and control than patients once had prior to the legislation. Please review these new rights below.

### **Control Over Your Health Information**

All healthcare providers and health plans are required to give you a written explanation of how they use and disclose your personal health information before they can treat you. You then can decide if a provider is protecting your privacy before you choose them as your caregiver. MABI must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. You have the right to say no, and you don't have to tell anyone why. Authorization of non-routine information is a one-time only, case by case, for the use defined by you.

### **Access to Your Health Information**

You can request copies of your medical records by asking for them. Healthcare providers are required to provide you with this copy within 60 days of your request. A cost may be associated with this service. Providers also must give you a history of non-routine disclosures, if you ask for it. You can also amend your medical records. You cannot change the existing record, but you can add notes or comments on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side.

### **Patient Recourse if Privacy Protections are Violated**

Every healthcare provider must inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201. If you decide to file a grievance either with us or with the Department, we are not allowed to discriminate or retaliate against you in any way.

Aside from these rights to access and control of your medical information under *HIPAA*, clear limits also exist on all healthcare providers regarding how they disclose medical information. The following are key aspects of these boundaries:

- Providers must ensure that health information is not used for non-health purposes. Health information may not be used for purposes not related to healthcare — such as disclosures to employers to make personnel decisions, or to financial institutions — without your explicit authorization.
- Clear, strong protections exist against using health information for marketing. The privacy rules set new definitions, restrictions, and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to minimum necessity. This does not apply to disclosure of records or treatment purposes, because physicians, specialists, and other providers may need access to the full record to provide quality care.

### **Exceptions**

There are situations where healthcare providers may not have to follow these privacy rules. They include: Emergency circumstances, identification of a body or the cause of death, public health needs, judicial and administrative proceedings, limited law enforcement activities, and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information.

We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

### **Authorization to Disclose Information to Mid America Balance Institute, Inc.**

I voluntarily authorize and request disclosure (paper, oral, and facsimile exchange,) of all my medical records including, but not limited to: physiological, psychiatric, or other mental impairments; drug abuse, alcoholism, or other substance abuse; sickle cell anemia; records which may indicate the presence of a communicable or venereal disease which may include hepatitis, syphilis, gonorrhea, and human immunodeficiency virus and/or Acquired Immune Deficiency Syndrome (AIDS) and tests for HIV.

For whom: All medical sources including but not limited to: hospitals, clinics, labs, physicians, psychologists, audiologists, mental health facilities, correctional treatment facilities, addiction treatment facilities, VA healthcare facilities.

I understand that circumstances can occur in which this information may be disclosed to the aforementioned facilities.

Please sign below that you have 1- received, read, and understand your HIPAA rights, and 2- authorize MABI to disclose medical information as necessary, as outlined above:

Date \_\_\_\_\_

Patient Name (printed) \_\_\_\_\_

Patient/Guardian(signature) \_\_\_\_\_

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## Computerized Posturography and VNG testing Waiver Form

- Computerized Posturography is a diagnostic test performed by specially-trained Mid America Balance Institute physical therapists to analyze your bodily systems related to your balance and your motor skills.
- The VNG test is a diagnostic test performed by specially-trained MABI audiologists to analyze your balance and how it is affected by your inner ears, vision, and a combination of both.

### **The benefits of having the computerized posturography and VNG diagnostic tests:**

- Both tests measure the function of three systems in your body that contribute to balance:
  - Eyes (visual system)
  - Inner ears (vestibular system)
  - Pressure, position, touching, and feeling (somatosensory system)
- Measures your balance control system
- Guides therapist in developing an accurate, customized treatment program for you
- Establishes a baseline understanding of your initial status to be able to re-test a month later to track your progress
- Directs The Balance Institute to precisely design and update your program to achieve maximum benefit for you
- Helps us modify your plan of care based upon your documented progress

### **Insurance Coverage**

MABI will bill your insurance company each time a test is performed. The MABI fee for these tests is the usual and customary charge for this test. If your insurance company does not pay for this procedure, you will be responsible for this balance due on your account. If you would like to pay at the time of service, you will receive a 20% discount. If your insurance company does pay us, we will refund your payment immediately.

### **Payment Acceptance**

I hereby agree to pay for each Computerized Posturography and VNG test performed by the Mid America Balance Institute if denied by my insurance company.

### **Payment Denial**

I choose not to have one of these tests performed during my evaluation/treatment process with the Mid America Balance Institute, Inc.

Please sign below that you have 1- received, read, and understand your diagnostic evaluations with MABI, Inc., and 2- allow MABI, Inc. to perform the aforementioned tests on you:

Date \_\_\_\_\_

Patient Name (printed) \_\_\_\_\_ Patient/Guardian(signature) \_\_\_\_\_

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