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Mid America Balance Institute

NEW PATIENT INFORMATION & REGISTRATION

TODAY'S DATE: ______________________

NAME: ___________________________________ GENDER: ___________ EMAIL: ________________________

BIRTHDATE: ____________ AGE: _______ MARITAL STATUS _____ SSN: _______________________________

ADDRESS: _____________________________________ CITY: ____________ STATE: ______ ZIP: __________

PHONE: __________________ EMERGENCY CONTACT NAME/PHONE: ____________________________________

CHIEF COMPLAINT: __________________________ DATE OF ONSET: ________ HEIGHT: ______ WEIGHT: ______

REFERRING Physician: ______________________ Last Dr Appt: ______________ Next Dr Appt: ________________

PRIMARY Care Physician: _________________________________

Please list up to 5 current medications; if more, please supply a list:

____

Have you had any diagnostic services for your current condition?

MRI X-RAY CT scan Other: ___________

Have you seen any specialists (i.e., cardiology, neurology, ENT) <u>for your condition</u>? If yes, please list:

____

Do you have any of the following conditions (*<u>circle yes or no for each)</u>*

Concussion/Head Injury If yes, when: ____________	YES	NO
Stroke/TIA If yes, when: ______________	YES	NO
Cancer	YES	NO
Location: ______________ Year: __________________		
Blood Clots	YES	NO
Diabetes	YES	NO
COPD	YES	NO
MS (Multiple Sclerosis)	YES	NO
Parkinson's Disease	YES	NO
Recent viral or bacterial infection in past 3-6 months? (Upper respiratory, ear infection, etc.)	YES	NO
COVID-19 If yes, when: ________________	YES	NO

Eye conditions or eye surgeries If yes, specify: ______________	YES	NO
Seizures	YES	NO
Osteoarthritis	YES	NO
Shingles	YES	NO
High Blood Pressure	YES	NO
Heart problems? If so, describe: _______________	YES	NO
Tobacco Use?	YES	NO
Migraine	YES	NO
Alzheimer's/Dementia	YES	NO
Autoimmune Disease	YES	NO
Anxiety/Depression	YES	NO
Neuropathy (numbness/tingling)	YES	NO

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TODAY'S DATE: ________________________

Please list any other pertinent medical conditions/history/surgeries:

____

____

Please describe your symptoms below:

____

____

____

____

When did your symptoms begin?	
How did your symptoms begin?	
When your symptoms are present, how long do they last? (Seconds, minutes, hours, days, etc.?)	
Have you fallen because of your problem?	YES NO
Do you fear falling because of your problem?	YES NO

Any provoking activities or positions that bring your symptoms on?

____

____

____

Overall, are your symptoms:
(circle one) IMPROVING BECOMING WORSE REMAINING THE SAME

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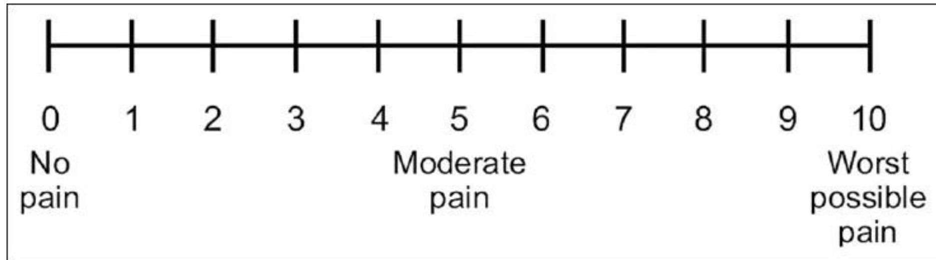
Are you experiencing any pain or discomfort at this time? YES NO
If yes, please circle your current pain rating on the scale below.



Please specify the location of your pain below:

WHEN YOUR SYMPTOMS ARE PRESENT, do you experience any of the following sensations?
(<u>circle all that apply</u>)

Room spinning	Drifting or falling toward one side	Blackouts/fainting
Headaches	Sensitivity to light or sound	Numbness in face/fingers
Slurred or difficult speech	Difficulty swallowing	Tingling of mouth/extremities
Spots before the eyes	Double vision or blurred vision	Confusion or memory loss
Difficulty hearing	Tinnitus (sounds in ears)	Nausea
Sweating	Lightheadedness	Neck pain
Discharge from ears	Pain in ears	Recent hearing changes

General Consent to Treat and Billing Policy

The following are the terms and conditions for health care services provided by Mid America Balance Institute. These authorizations must be signed by the patient or by the authorized representative for a minor or an incapacitated patient, and by the party financially responsible for the patient. **PLEASE READ EACH AUTHORIZATION CAREFULLY.**

1. **Consent to Treat:** I consent to and authorize examinations, testing, and treatment ordered or prescribed by my physician(s). This consent remains in effect for the purpose of providing continuing and future medical care and treatment. I understand the attending healthcare provider will explain to me the nature of my condition and recommended treatment and any associated risk involved with that treatment. I also understand they will explain to me the other ways my condition may be treated. I further understand this may include diagnostic testing, examinations, medical, audiology, and/or physical therapy treatment and no guarantees have been made to me regarding the outcome of this care.
2. **Authorization to Release Information:** I authorize Mid America Balance Institute to disclose and release any medical information or record of the patient to any health care professional or facility, insurance company, governmental organization, or third-party payor for further medical care and treatment, certification and payment of medical expenses, and discharge planning.
3. **Financial Responsibility:** I promise to pay Mid America Balance Institute for all costs and charges incurred or made for or on account of the patient. I understand that insurance can be billed as a courtesy not a responsibility by Mid America Balance Institute, and I am responsible for resolving disputed insurance or third-party payor claims in a timely and accurate manner. I agree that this duty and responsibility is not being assumed by Mid America Balance Institute. An Estimate of patient financial responsibility may be provided at time of service upon request. Payment of the balance is due when billed by Mid America Balance Institute.
4. **Medicare/Medicaid/TriCare Certification, Authorization and Assignment:** If eligible, I authorize Mid America Balance Institute to apply for benefits from, and submit claims directly to Medicare, Medicaid, or TriCare on behalf of the patient, and certify that the information given in applying for payment is correct. I understand that if the provider is not contracted, services are not covered, are not paid, or do not qualify for payment, I will be responsible for payment of incurred charges, and/or, deductibles and patient's portion of qualified covered charges.
5. **Automotive, Accidental, and Liability Insurance:** I understand that it is my responsibility to file these forms of insurance for payment. Mid America Balance Institute does **NOT** file these types of claims. The patient will be provided with the information needed to file their own claim. Payment is due at the time of service for all charges.
6. **Cancellation Policy:** A minimum of 24 hour notice is required to cancel your appointment. We understand that illness, family emergencies or bad weather are not planned and in consideration of these situations the cancellation fee will not be applied until the third cancellation/no show within the 24 hour period. There will be a $25.00 cancellation fee for those that have excessive cancellations/No Shows, (more than 2) at the discretion of Mid America Balance Institute.
7. **Collections:** In the event your account becomes past due, Mid America Balance Institute will allow you the opportunity to make payment arrangements. However, if no attempt has been made to bring your account current, Mid America Balance Institute will place your account with an outside collection agency. I agree to pay any and all costs of collection, including collection fees, interest accrued as provided by law, including reasonable attorneys' fees and expenses. I hereby authorize Mid America Balance Institute or its collection agent to contact me using electronic media including by cell phone.

I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS, AND I UNDERSTAND THAT MY SIGNATURE PERTAINS TO EACH OF THEM.

______________________________	______________________________
Patient Name (Please Print)	**Responsible Party if other than Patient**
______________________________	______________________________
Patient/Responsible Party Signature	**Date**

HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

I, ___________________________________, direct my healthcare and medical services providers and payers to disclose and release my protected health information described below to:

1) Name:_________________________________ Relationship: _________________________________

2) Name:_________________________________ Relationship: _________________________________

3) Name:_________________________________ Relationship: _________________________________

Form of disclosure: (check all that apply)

☐ An electronic record via secure email or through an online portal
☐ Hard copy

This authorization shall be effective until: (check one)

☐ All past, present, and future periods -OR-
☐ Date or event: ____________________________________unless I revoke it.
(NOTE: You may revoke this authorization in writing at any time by notifying your healthcare providers, preferably in writing.)

____ _____________________
Name of Individual Giving this Authorization Date of Birth

____ _____________________
Signature of Individual Giving this Authorization Date

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DIZZINESS HANDICAP INVENTORY

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/unsteadiness. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your dizziness/unsteadiness only.

YES	NO	SOMETIMES		
			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 problem?
			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 movies, dancing, or to parties?
			F7.	Because of your problem, do you have difficulty reading?
			P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?
			E9.	Because of your problem, are you afraid to leave your home without someone accompanying 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 house work 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 your 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?

INSTRUCTIONS: Put a check in **one** box that best describes you:

- ❏ Negligible symptoms (0)
- ❏ Bothersome symptoms (1)
- ❏ Performs usual work duties but symptoms interfere with outside activities (2)
- ❏ Symptoms disrupt performance of both usual work duties and outside activities (3)
- ❏ Currently on medical leave or had to change jobs because of symptoms (4)
- ❏ Unable to work for over one year or established permanent disability with compensation payments (5)

With Permission from: Jacobson GP, Newman CW. The development of the dizziness handicap inventory. Arch Otolaryngol Head Neck Surg 1990; 116: 424-427, Copyrighted 1990, American Medical Association.

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The Mid America Balance Institute has received a referral from your physician for a comprehensive vestibular and/or balance evaluation.

Prior to the appointment:

Please stop taking these medications or substances for a full ***48 hours*** prior to testing. If you have taken a medication or substance from this list you will be asked to reschedule as they can interfere with testing results:

- Alcohol
- Alprazolam (Xanax)
- Amphetamines (Adderall)
- Antivert **(Meclizine)**
- Ativan (Lorazepam)
- Benadryl (Diphenhydramine)
- Bonine
- Clonazepam (Klonopin)
- Diazepam (Valium)
- Dramamine (Dimenhydrinate)
- Marijuana
- Narcotics: Codeine, Hydrocodone (Lortab, Vicodin), Oxycodone (Percocet), Oxycontin, Dilaudid
- Scopolamine patch
- Promethazine (Phenergan)
- Prochlorperazine (Compro)

DO NOT *stop taking any medication for blood pressure control, cardiac or circulatory problems, diabetes, seizures or other medications for similar medical disorders. Please check with your pharmacist or the physicians who wrote the prescription regarding any questions or concerns.*

During the appointment:

You will be evaluated by one of our specialists to determine if dysfunction or abnormality exists with the inner ear which may be causing or contributing to your symptoms. Testing is extensive and takes approximately ***3 hours*** to complete. Please be advised that some dizziness is normal with testing, and is typically mild and short in duration. It is encouraged to bring someone to the appointment to drive you home, should you feel unwell afterwards.

Additional instructions:

- Wear comfortable clothing and flat, supportive shoes.
- Please arrive with a clean face. ***No facial or eye makeup.***
- *Avoid eating a heavy meal* at least 2 hours before appointment time.
- Part of your assessment may involve a hearing test. If you have had hearing testing performed within the last year, please bring a copy of your test results or let us know prior to your appointment so we can obtain a copy.

If you have any further questions of what to expect at your appointment, please don't hesitate to contact us!

Office Phone: (816) 246-1456 Office Fax: (816) 286-2774