The Scholl Center at Sound IQ
3105 S. Harvard Ave., Tulsa, OK 74135
Office: (918) 508-7601 Fax: (918) 508-7603
TheSchollCenter.com | SoundIQ.com

BALANCE

PATIENT INFORMATION

Full Name:_____ Clinician: _____

Appointment Date:_____ Appointment Time:_____

Greetings,

Welcome!
We have reserved the time above for your balance testing and evaluation. Please allow 3-4 hours for the full test battery and be certain to read all of the enclosed instructions. We are happy to answer any questions you have regarding the instructions or current medications.

The Scholl Center schedules 2-3 months in adavance for neurophysiology testing. You will receive a confirmation call 4 business days prior to your scheduled appointment. **Confirmation from you will need to take place no later than 3 business days prior to your appointment.** If you do not confirm your appointment, it will be canceled and filled by another patient.

If you cannot keep this appointment, please call to cancel or reschedule at least 2 business days in advance. You will be responsible for a $125 office charge for not giving proper notice or no-showing your appointment.

We look forward to seeing you soon. Please don't hesitate to call if you have any questions.

Sincerely,

Jacqueline R. Scholl

Jacqueline R. Scholl
AuD, CCC/A, Doctor of Audiology
Owner & Founder

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VNG PATIENT INFORMATION & INSTRUCTIONS

*Read 48 hours prior to your VNG procedure

What is a VNG?

A VNG is a balance evaluation also known as a Videonystagmography. The balance evaluation is a simple painless procedure where data will be collected to determine if you have any issues with your inner ear and balance system. This procedure will be analyzed by a licensed audiologist.

Certain medications can alter the results of this test and prevent an accurate evaluation of your balance system. Discontinue taking any sleep aids and/or medications specifically for dizziness––(Meclizine, Antivert, Valium, ect), and other strong sleeping pills and pain pills that can cause drowsiness, for 48 hours prior to your test, because these drugs can affect the results of testing.

These medications do not apply if you have been taking them for more than 6 months. If you have questions or for a list of medications that should be stopped, please call us at 918-508-7601.

7 Easy Steps to Prepare for Your Balance Evaluation

1. DO NOT wear any eye makeup. The eye makeup will affect the test- if you wear eye makeup, you will be asked to remove it when you arrive.

2. No perfumes or scented lotions.

3. No nicotine the day of the test. This includes ALL tobacco products.

4. You may eat as usual, although no heavy meals just prior to testing.

5. Please wear comfortable clothes. Women should wear slacks, as you will be lying down for a portion of the test.

6. Make arrangements for transportation as your ability to drive following the test may be impaired due to imbalance or dizziness.

7. A failure to follow directions may result in rescheduling your appointment.

IMPORTANT BILLING INFORMATION: There will be charges for this procedure. If you have insurance that will cover the procedure, we will file this for you. Any remaining balance will be patient's responsibility.

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CONFIDENTIAL COMMUNICATION REQUEST

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____ (PRINT YOUR NAME) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Telephone Contact Information:

Home #:_____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Work #: _____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

Cell #: _____-_____-_____ ☐ Do ☐ Do Not ☐ Leave messages on my voice mail.

I want to recieve ☐ **text** ☐ **email notifications**

PLEASE LIST OTHER PERSON THAT MAY BE CONTACTED WITH CONFIDENTIAL INFORMATION

Please note: that if you fail to list parties who can be contacted with confidential information The Scholl Center will not disclose any information about the patient and/or patient treatment including but not limited to: appointment times, test results, medical records, etc.

1. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

2. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

Sign Patient Full Name: _____ *DOB:* _____

Print Patient Full Name: _____ *Date:* _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian

☐ Guardian or Conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

☐ Other (specify):_____

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CONSENT FOR ROUTINE MEDICAL TREATMENTS

The Scholl Center for Communication Disorders, P.L.L.C. and its employees are here by authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by The Scholl Center for Communication Disorders, P.L.L.C. and are accessible to its personnel and medical staff for use in my care. The Scholl Center for Communication Disorders, P.L.L.C. personnel and physicians may use and disclose information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. The Scholl Center for Communication Disorders, P.L.L.C. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of The Scholl Center for Communication Disorders, P.L.L.C. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to The Scholl Center for Communication Disorders, P.L.L.C., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for The Scholl Center for Communication Disorders, P.L.L.C. charges payable to the insured are to be made payable to The Scholl Center for Communication Disorders, P.L.L.C. and that insurance benefits for services provided by the physicians in the hospital setting otherwise payable to the insured are to be made payable to the physician(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bill for which you are liable, subject to the rules of coordination of benefits.

PRE-CERTIFICATION POLICY

You understand that The Scholl Center for Communication Disorders, P.L.L.C. will assist with insurance pre-certification requirements which are the responsibility of the policyholder and/or the hospital, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by The Scholl Center for Communication Disorders, P.L.L.C. Charges for services and goods shall be at The Scholl Center for Communication Disorders, P.L.L.C. billed charges unless otherwise agreed to in writing by The Scholl Center for Communication Disorders, P.L.L.C.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as the original. Signature of Patient of Patient's Legally Authorized Representative (Documentation Must Be Provided)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by The Scholl Center for Communication Disorders, P.L.L.C. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy for your personal use. I have received a copy of The Scholl Center for Communication Disorders, P.L.L.C. Notice of Privacy Practices:

Patient/ Representative:_____ Legal Authority of Representative:_____ Date :___/____/____

Patient Sign:_____ DOB: ___/___/_____

Basis for refusal, if refused:_____

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Office and Financial Policies

INSURANCE, RESCHEDULING, PAYMENT

Thank you for choosing The Scholl Center for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Insurance

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if The Scholl Center is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services, and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. The Scholl Center cannot submit a claim to any insurance carrier if we do not have all the required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific goods or services you are requesting. The Scholl Center commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstances. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

Cancellation Policy

24 HOUR NOTICE

+ Hearing Assessments
+ Hearing Aid Checks
+ Physical Therapy treatment
+ Physical Therapy evaluation
+ Tinnitus Evaluation
+ Cochlear Implant mappings

$25 fee for no-show appointments and late rescheduling.

72 HOUR NOTICE

+ Balance Evaluation

Due to the length of appointment and necessary withdrawal of certain medications, there will be no exceptions made for balance evaluations.

$125 fee for no-show appointments and late rescheduling.

NEED TO RESCHEDULE

+ Inform

Let us know in the appropriate amount of time if you need to reschedule.

+ Cancellation fee

We reserve the right for a cancellation fee for any no show appointments. This is the patient's responsibility and will not be billed to insurance.

Running Late

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 10 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you to come back later in the day if a later appointment is available or reschedule to another date and time.

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Office and Financial Policies

INSURANCE, RESCHEDULING, PAYMENT

Payment

Payment in full is due at the time services are provided. You are responsible to pay all out of pocket expenses such as co-pay, co-insurance, and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of any device, accessory, or supplies.

Our Policy

The Scholl Center accepts payment in the form of cash, check, Visa, Mastercard, and Discover. We also offer a third-party credit program through Wells Fargo and AbleTech. *There is a $45 fee for bounced or returned checks.*

It is also the policy of The Scholl Center that we maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charges to your credit card without first informing you of this in writing. You then have the right to use an alternative form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. The Scholl Center reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

☐ *I understand and agree to the office and financial responsibilities of The Scholl Center at Sound IQ.*

☐ *I am the patient.*

Patient Print Name: _____ *DOB:* _____

Patient Signature: _____ *Date:* _____

☐ *I am the parent or guardian of the patient.*

Parent/Guardian Print Name: _____ *DOB (of parent/guardian):*_____

Parent/Guardian Signature: _____ *Date:* _____

*Print patient's full name:*_____ *Patient's DOB:*_____

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GENERAL

PATIENT INFORMATION

Full name:_____Preferred name:_____ Today's date:_____

DOB: ____/____/_____ Sex: __ Address:_____ City:_____ State:____ Zip:_____

Primary Case Physician:_____ Referring Doctor:_____

Social Security #:_____-_____-_____ Direct phone #:_____-_____-_____ Secondary phone #:_____-_____-_____

Email address:_____

RESPONSIBLE PARTY INFORMATION

Last name:_____ First name:_____ Middle Initial:___ Social Security #: _____-_____-_____

Relationship to Patient:_____ Home/Cell #: _____-_____-_____ Work #: _____-_____-_____

Employer Name: _____ Employer Phone #:_____-_____-_____

PRIMARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:_____ Subscriber's name:_____ Policy ID #:_____

Subscriber's DOB:____/____/_____ Group #:_____ Relationship to Patient:_____

Policy Effective Date:____/____/_____ Insured's Social Security #:_____-_____-_____ Employer:_____

Employer's #_____-_____-_____

SECONDARY INSURANCE (POLICY HOLDER'S INFORMATION ONLY)

Insurance Company:_____ Subscriber's name:_____ Policy ID #:_____

Subscriber's DOB:____/____/_____ Group #:_____ Relationship to Patient:_____

Policy Effective Date:____/____/_____ Insured's Social Security #:_____-_____-_____ Employer:_____

Employer's #_____-_____-_____

EMERGENCY CONTACT INFORMATION

1. Name:_____ Relationship to Patient:_____ Phone #:_____-_____-_____

MEDICARE PATIENTS

1. Do you receive home health and/or skilled nursing services? ___YES / ____NO

2. If you answered **yes**, please write the name of the entity/facility who provides the services here:

Facility Name:_____ Phone #: _____-_____-_____

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/ Guardian Print Name:_____ Relationship to Patient:_____

Patient/Guardian Signature:_____ Date:_____

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PATIENT INFORMATION FOR MEDICATION LIST

Full name:_____ DOB: ____/____/_____ Today's date:_____

NEW MEDICATIONS PIROR TO ONSET OF SYMPTOMS

Name of Medication	Dosage (mg)	Frequency	Form (Pills, drops, etc)

MEDICATION LIST

Name of Medication	Dosage (mg)	Frequency	Form (Pills, drops, etc)

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PATIENT QUESTIONNAIRE

Full name:_____ Preferred name:_____ Today's date:_____

DOB: ____/____/_____ Sex: __ Age: ____ Height: ____feet ____inches Weight:_____ Occupation:_____

Address:_____ City:_____ State:___ Zip:_____ Direct phone #:_____-_____-_____

Primary Care Physician: _____ Primary Care Physician's Phone #:_____-_____-_____

Referring Physician: _____ Referring Physician's Phone #: _____-_____-_____

CURRENT MEDICAL HISTORY

Describe in your own words the sensation you feel, without using the word dizzy:_____

_____

When did it begin?_____

Had you just been sick prior to onset of symptoms, if yes with what?_____

_____

PAST MEDICAL HISTORY

	YES	NO		YES	NO
Headaches or migraines	☐	☐	Arthritis	☐	☐
High or Low Blood Pressure	☐	☐	Neck Problems	☐	☐
Diabetes	☐	☐	Back Problems	☐	☐
Low Blood Sugar	☐	☐	Weakness	☐	☐
Heart Disease	☐	☐	Paralysis	☐	☐
Thyroid Disease	☐	☐	Tremor	☐	☐
Pulmonary Problems	☐	☐	Neuromuscular Disease	☐	☐
Asthma	☐	☐	Autoimmune Disease	☐	☐

CURRENT MEDICAL PROBLEMS

List your current medical problems and length of illness

SURGERY

List all surgery performed, including all eye surgeries, and approx. dates.

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STUDIES

(Hearing, balance testing, X-rays, MRI, scans and dates)

LIFESTYLE

	YES	NO
Do you live alone? If not who lives with you?	☐	☐
Do you have stairs in your home? If yes, how many?	☐	☐
Do you smoke? If yes, please indicate how much per day?	☐	☐
Do you drink alcohol? If yes, how much?	☐	☐
Do you drink coffee? If yes, how much?	☐	☐
Do you drink soft drinks? If yes how much?	☐	☐
Do you feel lightheaded or have a swimming sensation when you are dizzy?	☐	☐
Do you find yourself breathing faster or deeper when excited or dizzy?	☐	☐
Did you recently change eye glasses?	☐	☐
Is your dizziness related to moments of stress?	☐	☐
Is your dizziness related to menstrual period?	☐	☐
Is your dizziness related to overwork or exertion?	☐	☐
Is there stress in your life recently? Explain:	☐	☐

DO YOU EXPERIENCE

	YES	NO
Spinning in circles?	☐	☐
Falling to one side?	☐	☐
World spinning around you?	☐	☐
Feeling off balance?	☐	☐
Balance issues only when standing or walking? Explain?	☐	☐

FOLLOWING TO REFER TO A DIZZY SPELL

	YES	NO
Do the dizzy spells come in attacks?	☐	☐
How often?_____ How long is each attack? (Circle one) **Seconds Minutes Hours/Days**	☐	☐
Date of first dizzy spell:_____/_____/_____	☐	☐
Are you free from dizziness between attacks?	☐	☐
Does your hearing change with an attack?	☐	☐
Are you more dizzy in certain positions? Which ones?	☐	☐

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FOLLOWING TO REFER TO A DIZZY SPELL

	YES	NO
Are you nauseated during an attack?	☐	☐
Had a recent cold or flu preceding dizzy spells?	☐	☐
Fullness or pressure or ringing in your ears?	☐	☐
Recent or onset of pain or discharge in your ear?	☐	☐
Trouble walking in the dark?	☐	☐
Are you better if you sit or lie perfectly still?	☐	☐
Dizzy when... ☐ **lying down?** ☐ **Arising from bed?** ☐ **Looking up?** ☐ **Turning your head quickly?** ☐ **Bending over?**	☐	☐
Do you get dizzy when rolling over in bed? ☐ **Left** ☐ **Right**	☐	☐
Do any of your family members have dizziness? Who?	☐	☐
Do you know when you're about to have a dizzy-attack?	☐	☐

DESCRIBING YOUR FALLS

	YES	NO
Have you fallen on the ground?	☐	☐
Have you injured yourself? If yes, explain	☐	☐
Do you stumble, stagger or side-step while walking?	☐	☐
Do you drift from one side while you walk? **Left** **Right**	☐	☐

OTHER EXPERIENCES

	YES	NO
Do you black out or faint when you are dizzy?	☐	☐
Are you dizzy or unsteady constantly?	☐	☐
Do you have severe or reoccurring headaches?	☐	☐
Headaches where light or loud noises make the headache worse?	☐	☐
Dizziness brought on by headaches?	☐	☐
Do you suffer from pain other than headaches? Explain?	☐	☐
Double or blurry vision?	☐	☐
Numbness in your face or extremities?	☐	☐
General weakness, fatigue or clumsiness in arms, and/or legs?	☐	☐
Paralysis or loss of function in arms or legs? **Left** **Right**	☐	☐
Slurred or difficult speech?	☐	☐

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OTHER EXPERIENCES...CONTINUED

	YES	NO
Difficulty swallowing?	☐	☐
Tingling around your mouth?	☐	☐
Spots before your eyes?	☐	☐
Ever had weakness or faintness a few hours after eating?	☐	☐
Are you dizzy mainly when you sit or stand up too quickly?	☐	☐
Jerking of arms or legs involuntarily?	☐	☐
Head injury with loss of consciousness?	☐	☐
Confusion or memory loss?	☐	☐
Decreased movement of the neck and neck pain?	☐	☐
Are you allergic to any medicine? Explain?	☐	☐
Are you allergic to anything? Explain?	☐	☐

YOUR HEARING

	YES	NO
Do you experience.... **Difficulty hearing** **Fullness in the ears** **Discharge from the ears** **Pain in the ears**	☐	☐
Ringing in the ears? (Describe the sound)	☐	☐
Hearing changing... **Better** **Worse**	☐	☐
Previous ear infections?	☐	☐
Previous ear surgery? Explain and when?	☐	☐
Exposure to loud noises at any time in your life?	☐	☐
Family history of Deafness? **Mother** **Father** **Brother** **Sister** **Grandparents** **Other:**	☐	☐
Do you currently wear hearing aids and for how long have you worn them?	☐	☐
Are you happy with the performance of your hearing aids?	☐	☐
Has your hearing loss been.... **Gradual** **Sudden**	☐	☐
Do you have problems with excessive ear wax build up?	☐	☐
When was the last time you had your hearing checked? Date:	☐	☐

ADDITIONAL INFORMATION

If you have anything else to tell us about your particular balance problem please provide detailed notes.