PATIENT INFORMATION **(incomplete forms will delay your appointment)**

Name: _____ ☐ MALE ☐ FEMALE
First M. Last

Address: _____ Apt/Unit#: _____

City: _____ State: ____ Zip Code: _____ Home Phone: ( ) _____-_____

Work Phone: _____ Mobile Phone: _____ Email: _____

SS#: _____-_____-_____ Date of Birth: ____/____/_____ Age: _____ Marital Status: _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone: ( ) _____-_____

Do you live in a Skilled Nursing Facility? ☐ Yes ☐ No If yes, please provide name/phone: _____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer: _____ Address: _____ City: _____ State:____ Zip: _____

MEDICAL DOCTOR INFORMATION:

Referring Physician: _____ Phone: ( ) _____-_____

Address: _____City: _____ State: _____ Zip: _____

Family Physician: _____ Phone: ( ) _____-_____

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM: _____

PLEASE LIST OPERATIONS YOU HAVE HAD: _____

PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:

_____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

☐ Heart Disease	☐ Tuberculosis	☐ Artificial Joints	☐ Diabetes	☐ Cancer	☐ Ringing in Ears
☐ Pacemaker	☐ Breathing Problems	☐ Back Problems	☐ Stroke	☐ Depression	☐ Infection / Wounds
☐ Circulation Problems	☐ Emphysema / COPD	☐ Neck Problems	☐ Parkinson's Disease	☐ Nausea	☐ Blood Disorders
☐ High Blood Pressure	☐ Asthma	☐ Arthritis	☐ Epilepsy / Seizures	☐ Ulcer Disease	☐ Glaucoma

Other: _____

ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover

☐ Primary Insurance: _____ _____ _____
Name of Insurance ID # Group#

Primary Card Holder Name: _____ Primary Card Holder Date of Birth: ____/____/_____

☐ Secondary Insurance: _____ _____ _____
Name of Insurance ID # Group#

Initial Here _____ **I understand that I am ultimately responsible for the balance on my account for any professional services rendered.** I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

AUTHORIZATION FOR TREATMENT

The patient /legal guardian authorized The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature:_____ Date:_____

AUDIOLOGY PATIENT QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

Please spend a few minutes answering these questions regarding your history and symptoms. Answer them to the best of your ability, but please be assured that how you answer will not affect your evaluation.

Put an 'X' in either the YES box or the NO box,
whichever best describes your feelings most accurately.

Do you have any of the following symptoms?

YES	NO	
☐	☐	Do you have difficulty in hearing? ☐ Both ears ☐Right ear ☐ Left ear
		When did it start? _____ Is it getting worse? _____
☐	☐	Do you have noise in your ears (tinnitus)? ☐ Both ears ☐ Right ear ☐ Left ear
		Describe the noise_____
☐	☐	Does the noise change?
		If YES, when does it change? _____ If YES, how does it change? _____
☐	☐	Does anything stop the noise or make it better?_____
☐	☐	Do you feel fullness or stuffiness in your ears? ☐ Both ears ☐ Right ☐ Left
☐	☐	Do you have pain in your ears? ☐ Both ears ☐ Right ☐ Left
☐	☐	Do you have discharge from your ears? ☐ Both ears ☐ Right ☐ Left
☐	☐	Have you ever been exposed to loud noise? If yes, explain_____
☐	☐	Do you wear hearing aids? ☐ Both ears ☐ Right ☐ Left
		If YES, Do you feel your hearing aids help you hear better? ☐ Yes ☐ No

Please check yes, *sometimes, or no* for each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

		Yes 4	Sometimes 2	No 0
E-1	Does a hearing problem cause you to feel embarrassed when you meet new people?…….	____	____	____
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family? ……	____	____	____
S-3	Do you have difficulty hearing when someone speaks in a whisper?……	____	____	____
E-4	Do you feel handicapped by a hearing problem?……..	____	____	____
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?…….	____	____	____
S-6	Does a hearing problem cause you to attend religious services less often than you would like? ……	____	____	____
E-7	Does a hearing problem cause you to have arguments with family members?…….	____	____	____
S-8	Does a hearing problem cause you difficulty when listening to radio or television?……..	____	____	____
E-9	Do you feel that any hearing difficulty limits or hampers your personal or social life? ……	____	____	____
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? ……	____	____	____

Do not write below this line.

TOTAL SCORE: _____ E -TOTAL:_____ S -TOTAL_____

THE AMERICAN INSTITUTE OF BALANCE, INC.

SUMMARY OF PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

Adhere to the standards set forth in the Notice of Privacy Practices.

Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose PHI to remind patients of their appointments unless they instruct us not to.

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:

Implement reasonable measures to protect the integrity of all PHI maintained about patients.

Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:

Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.

All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Richard E. Gans, Ph.D., 727.398.5728.**

FINANCIAL POLICY

As a courtesy to you, our patient, we will file your insurance for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your procedure is a non-covered benefit, according to your insurance policy, it becomes an expense billable to you.

If you are a member of an HMO, *IT IS THE PATIENT'S RESPONSIBILITY* to obtain any and all necessary referral authorizations PRIOR TO YOUR VISIT. If the authorization is not in our office at the time of service, it may be necessary to reschedule your visit if you choose not to pay at the time services are rendered.

All co-payments are due at the time you sign in at the front desk, and are payable by check, cash or credit card (Visa, Mastercard, Discover, or American Express). If a check is returned by your bank for any reason, you will be charged a $39.00 Returned Check Fee, which will be added to your account, and must be paid in full by either cash or credit card prior to any follow up visits.

If you require FMLA paperwork to be completed by one of our staff, there will be a charge of $35.00 payable the day you pick your paperwork up from the office.

There will be a fee of $25.00 charged to your account for any missed appointments that are not cancelled 24 hours in advance.

If you are a SELF PAY PATIENT with no insurance coverage, all fees are due and payable at the time services are rendered, unless prior arrangements have been made with our Billing Department.

It is our policy to obtain all pertinent information in order to identify you as our patient. Included is your social security number and a copy of your driver's license or photo identification. This information is protected by the HIPAA laws.

If you are a PARENT / GUARDIAN OF A MINOR, it is the responsibility of the parent who is seeking treatment for the child to ensure that payment is rendered accordingly.

By signing below, I understand that I AM RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED. If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% and the outstanding balance on my account, plus any attorney's fees.

I ACKNOWLEDGE RECEIPT OF THIS FINANCIAL POLICY
AND A COPY SHALL REMAIN IN MY CHART.

RELEASE OF INFORMATION

By signing below, I authorize Doctors Gans, Jagger, Kurtzer, Dawson, and Malkiwiecz to release any information with regard to my treatment, for insurance purposes. I also authorize the above physicians to release my information to physicians or institutions as necessary for my treatment.

I understand that any information given with regard to my treatment shall remain CONFIDENTIAL and will be released only as necessary to my care or treatment.

Signature _____ Date _____

Print _____

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)
The American Institute of Balance ®	1851392849

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, John Rice to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, John Rice , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an Practitoner Representative
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address 8200 Bryan Dairy Rd Suite 340		Phone Number (with Area Code) (727) 398-5728
City Largo	State FL	Zip Code 33777

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

THE AMERICAN INSTITUTE OF BALANCE, INC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of **THE AMERICAN INSTITUTE OF BALANCE'S**
Patient Name

Summary of Privacy Practices.

_____ _____
Signature of Patient Date

Please list the names of individuals you authorize us to share medical information with:

Name:	**Phone #:**	**Relationship to Patient:**
_____	_____	_____
_____	_____	_____
_____	_____	_____