Enclosed you will find information about Midwest Dizziness and Balance Institute. This testing has been ordered to further assist your physician in determining the cause of your dizziness and/or balance concerns.

Please review the material and complete all the forms 48 HOURS prior to your appointment. This is essential as there are eating, drinking, and medication restrictions in place for this appointment.

If you have any questions, please call our office at (314) 384-8088. We will call you within 72 hours of your appointment with your doctor to schedule all your tests. Please call us only if you do not hear from us within 72 hours.

Our Location

12380 Olive Blvd
Creve Coeur, Mo, 63141

Phone: (314)384-8088
Fax: (636)238-4388
www.midwestdizzyandbalance.com

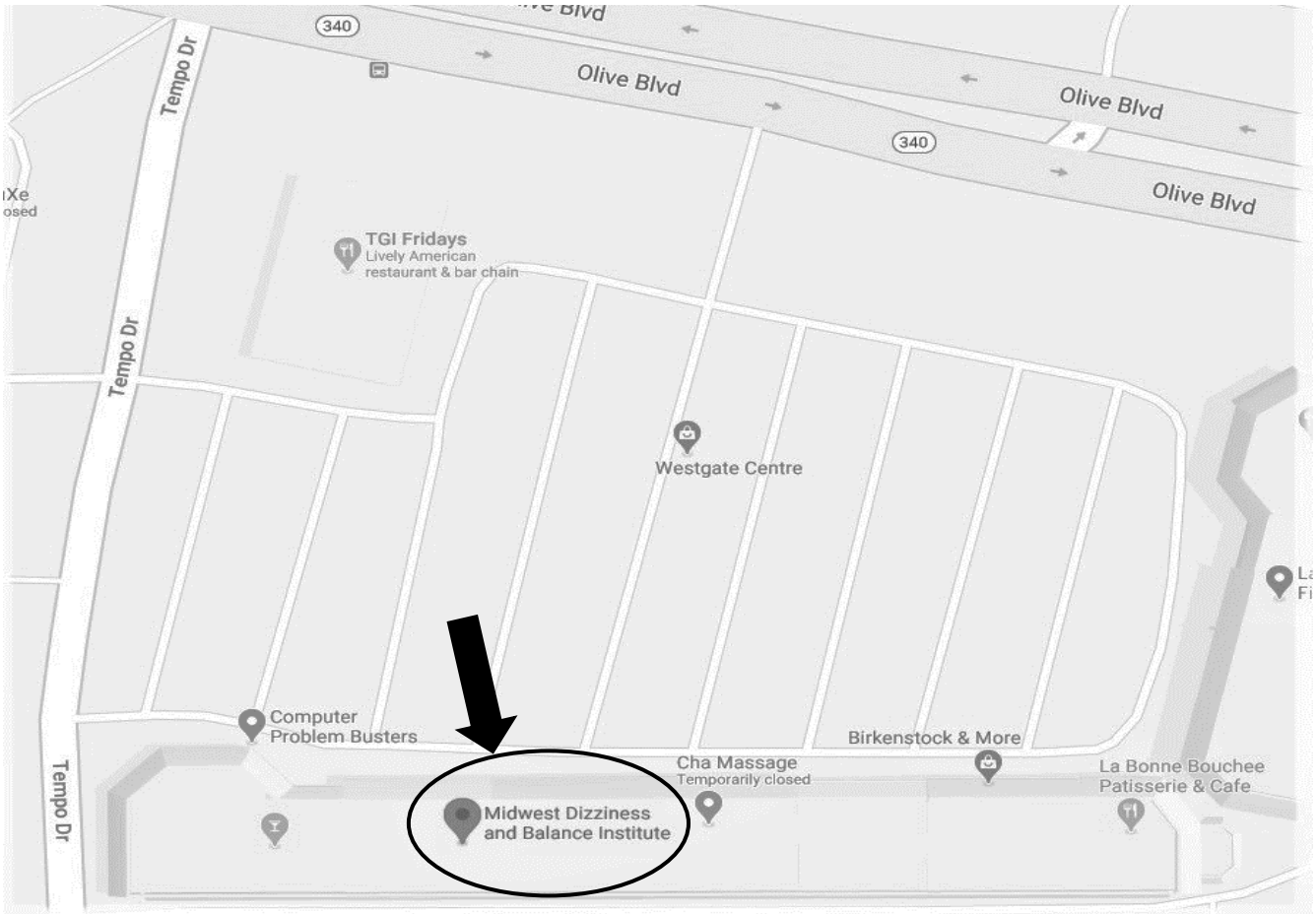
Please arrive 15 minutes prior to your appointment with **all your forms already completed.**

If you have any questions or need to change your appointment, please call **314-384-8088.**

DRIVING DIRECTIONS:

We are located in Creve Coeur, ½ mile West of I-270 on Olive Boulevard in the Westgate Center Plaza. We are neighbors to TGIF, and La Bonne Bouchee.

- **From North County:** Travel I-270 South and take Exit 14 (Olive Blvd). Travel West on Olive for 0.5 miles until Tempo Drive where you will take a Left at the stop light. Our Institution will be in the plaza on your left.
- **From Saint Charles via I-70 or MO-364:** Take MO-364 or I-70 East to I-270 South. Travel South on I-270 and take Exit 14 (Olive Blvd). Travel West on Olive for 0.5 miles until Tempo Drive where you will take a Left at the stop light. Our Institution will be in the plaza on your left.
- **From South Country:** Travel I-270 North and take Exit 14 (Olive Blvd). Travel West on Olive for 0/5 miles until Tempo Drive where you will take a Left at the stop light. Our institution will be in the plaza on your left.
- **From Illinois or Downtown via I-64/40:** Travel West on I-64/40 to I-270 North. Travel North on I-270 for 2 miles and take Exit 14 (Olive Blvd). Travel West on Olive for 0.5 miles until Tempo Drive where you will take a Left at the stop light. Our institution will be in the plaza on your left.



Patient Instructions

ABOUT THE APPOINTMENTS:

Your Audiologist will ask you questions about your medical history to gain insight on your overall health. Next, a comprehensive set of testing will be performed during the approximately3 and a half hour appointment to assess your overall ear health and to determine your vestibular function in a static (at rest) and dynamic (while moving) state. Prior to each test, an explanation will be given so that you know what to expect. All tests are simple and painless.

If you drive yourself to the appointment, plan an additional 15 to 30 minutes before you leave the office, as a few of the tests may cause a sensation of motion that may linger.
If possible, we encourage you to have someone drive you to and from your appointment. **If you have family, friend(s), or a caregiver with you, they will be asked to wait outside of the building during the Covid-19 outbreak.**

For your comfort and convenience:

- Dress comfortably. Women should avoid wearing skirts or dresses as part of the test requires lying down. You may want to bring a jacket or sweater; it generally stays cool in our office.
- Do not wear any makeup (including foundation, mascara, and eyeliner). Some tests will require placing small adhesive electrodes on the face and neck.
- Wear your glasses instead of contact lenses.
- If you wear hearing aids, please wear them and/or bring them with you to your appointment.

About your results appointment:
After your appointment, each test will be carefully analyzed and reviewed. This process is just as important as testing, so please understand that your test results will not be discussed in detail with you until 2 to 4 business days after your visit. Following the interpretation of the testing, you will return for a visit to review your results with your audiologist. A detailed report will also be sent to your referring physician regarding our conclusions and recommendations.
About treatment:
Treatment plans tailored to addressing vestibular impairments often involve in-clinic therapy sessions on a regular basis (2x's week) over several weeks (6 weeks), so it is

important that you are available to participate after your testing is complete to make you feel well again.

Medications: Always consult your doctor before discontinuing any prescribed medications. Certain medications significantly affect the tests. They are listed below. If you have any questions, you will need to check with your prescribing physician before you stop any of these medications. Please do not call our office about medications, as we cannot assist you with medications other physicians have prescribed.

It is recommended that the following vestibular suppressants be weaned prior to the test.

- **Anti-histamines**: Chlor-trimeton, Disophrol, Benadryl, Teldrin, Hismanol, Claritin, Allegra, Zyrtec, nearly all over-the-counter allergy or cold medicines
- **Anticholinergics:** Atropine, Belladonna, Hyoscyamine and Scopolamine
- **Benzodiazepines:** Diazepam (Valium), clonazepam, lorazepam and alprazolam (should not be stopped suddenly because of potential withdrawal symptoms)

Vestibular suppressants are drugs that reduce the intensity of vertigo and nystagmus (eye movements) evoked by a vestibular imbalance. These also reduce the associated motion sensitivity and motion sickness. Vestibular suppressants should only be used in acute cases to alleviate the stressful symptoms. Prolonged use may generate a chronic vestibular imbalance.

Below is a partial list of medications that **should <u>not</u> be taken for 48 hours prior to testing.** Ask your doctor if you have concerns about discontinuing your medications.

- **Alcohol:** beer, wine, liquor, cough medicine
- **Analgesics/Narcotics:** Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
- **Anti-vertigo:** Antivert, Meclizine, Ru-vert
- **Anti-nausea:** Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopolamine, nearly all motion sickness patches or medications
- **Sedatives:** Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pills
- **Tranquilizers:** Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanax

You may take blood pressure medications, heart medications, thyroid medications, Tylenol, insulin, and estrogen.

Other limitations:

- NO caffeine (coffee, soda, tea, etc.) for 4 HOURS before the test. Please limit caffeine to no more than 8 ounces the day of testing.
- NO smoking for 4 HOURS before the test
- NO eating or drinking for 4 HOURS before the test

MIDWEST DIZZINESS AND BALANCE INSTITUTE

Dizziness Questionnaire

Patient Name _____ **Date of Birth** _____ **Date** _____
ENT Physician _____ **Primary Care Physician** _____

1. **Describe your symptoms:** _____
_____
_____
2. **When did your symptoms begin?** _____
3. **Onset nature:** ☐ Gradual ☐ Sudden
4. **Select all that apply <u>DURING</u> your dizzy spells:**

☐ Preceded by flu/cold
☐ Spinning sensation (vertigo)
☐ Swaying/Rocking sensation
☐ Falling to the Right side
☐ Fall to the Left side
☐ Trouble walking in the dark
☐ Changes in your hearing
☐ Nausea
☐ Vomiting
☐ Perspiration, shortness of breath, or feeling of panic
☐ Lightheadedness or swimming sensation
☐ Better if sit or lie still
☐ Fullness/pressure in ears
☐ Ringing in the ears
☐ Stress
☐ Menstrual period
☐ Hormonal changes
☐ Overwork or exertion
☐ Headaches/Migraines
☐ Sensitivity to loud noises
☐ Sensitivity to light

5. **Imbalance when walking?** ☐ Yes ☐ No ☐ to the right ☐ to the left
6. **Comes in attacks or episodes?** ☐ Yes ☐ No
7. **How often?**

☐ Daily ☐ Multiple times a day ☐ Weekly ☐ Monthly ☐ Multiple times a year ☐ Annually

8. **How long do they last?** ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
9. **When was the last attack or episode?** _____
10. **Are you completely free from dizziness between attacks/episodes?** ☐ Yes ☐ No
11. **Do you have any warning signs prior to an attack/episode?** ☐ Yes ☐ No
    If yes, please explain: _____
12. **Have you had any head injury or trauma within the last 12 months or around the onset of dizziness symptoms?** ☐ Yes ☐ No
    If yes, please explain: _____
13. **Dizziness/Imbalance worsens with or triggered by:**

☐ Standing
☐ Walking
☐ Walking in the dark
☐ Transferring to standing from sitting or supine position
☐ Looking up/down
☐ Turning to left or right

☐ Bending over
☐ Loud sounds
☐ Pressure changes
☐ Laying down in bed
☐ Changing positions in bed
☐ Stress/Fatigue
☐ Visual stimulation
☐ Quick head movements
☐ Riding in an automobile or elevator
☐ Bright lights
☐ Straining (coughing, sneezing, lifting heavy objects)
☐ Specific food or drink: _____
☐ Other: _____

14. Is there anything you can do to help alleviate your dizziness? ☐ Yes ☐ No

If yes, please explain: _____

15. Other sensations include:

☐ Blacking out or fainting when dizzy
☐ Dizzy or unsteady constantly
☐ Severe or recurrent headaches
☐ Double or blurry vision
☐ Numbness in the face or extremities
☐ Weakness/clumsiness in arms or legs
☐ Slurred or difficult speech
☐ Tinging around mouth
☐ Spots before eyes
☐ Jerking of arms or legs
☐ Dizzy when stand up quickly
☐ Weakness/Faintness after not eating
☐ Difficulty swallowing
☐ Migraine

16. My current symptoms also include (can occur with or without dizziness episode):

☐ Difficulty hearing in Right ear
☐ Difficulty hearing in Left ear
☐ Ringing in Right ear
☐ Ringing in Left ear
☐ Fullness in Right ear
☐ Fullness in Left ear
☐ Pain in Right ear
☐ Pain in Left ear
☐ Discharge in Right ear
☐ Discharge in Left ear
☐ Hearing change in Right ear
☐ Hearing change in Left ear
☐ Exposure to loud noise in Right ear
☐ Exposure to loud noise in Left ear
☐ History of Right ear infection
☐ History of Left ear infection

17. Have you ever had previous ear surgery?

☐ Yes ☐ No ☐ Years ago ☐ Months ago ☐ Procedure: _____

18. Have you ever worn or currently wear hearing aids? ☐ Yes ☐ No

19. Medical History also includes:

☐ Back or neck surgery
☐ Back or neck pain
☐ Back or neck injury
☐ Seasickness or car sickness
☐ Motion intolerance
☐ Sensitivity to light and/or sound
☐ Not applicable

20. What physicians or specialists have you seen previously <u>FOR YOUR DIZZINESS?</u>

☐ Primary Care Physician
☐ ENT
☐ Cardiologist
☐ Neurologist
☐ ER or Urgent Care
☐ Chiropractor
☐ Physical Therapist # of visits ____
☐ Other: _____

22. What tests have been done previously <u>FOR YOUR DIZZINESS?</u>

☐ Hearing ☐ MRI ☐ CT Scan ☐ Bloodwork ☐ Angiogram ☐ Other: _____

MIDWEST DIZZINESS AND BALANCE INSTITUTE

Health Questionnaire

Please complete all entries.

Patient Name: _____ **Date of Birth:** _____

A. Medication: List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency	Condition being treated

B. Have there been any recent changes to your medications? (change in dosage or new medication)

☐ Yes ☐ No

If yes, please explain nature and date of change: _____

_____

C. Allergies to medications: _____

D. Surgical History/Hospitalizations: List all surgeries. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Conditions/Illness/Surgery

E. Social History: Please check appropriate box and give amount.

1. Do you smoke? ☐ Yes ☐ No How many packs per day? ☐ Less than ½ ☐ ½-1 ☐ 1-3 ☐ 3+
2. Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? ☐ 1 ☐ 2-5 ☐ 6-10 ☐ 11+
3. Do you drink caffeine products? ☐ Yes ☐ No What kind? ☐ tea ☐ coffee ☐ soda

If you drink caffeine products, how many 8 oz cups per day? 1-2 2-3 3-4 ☐ 4+ ☐ ☐ ☐

F. Symptom Review: Please select to indicate if you have had any of the following symptoms or diseases:

Constitutional
- ☐ Chronic fatigue
- ☐ Weight loss
- ☐ Weight gain

Eyes
- ☐ Blurry vision
- ☐ Vision loss
- ☐ Cataracts
- ☐ Crossed eye/lazy eye
- ☐ Double vision
- ☐ Spots before eyes

ENT
- ☐ Hearing loss
- ☐ Otalgia
- ☐ Otorrhea
- ☐ Ears, itching
- ☐ Tinnitus
- ☐ Sound sensitivity
- ☐ Facial weakness
- ☐ Facial pain
- ☐ Vertigo
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Sinus trouble

General
- ☐ Cancer type:____
- ☐ Currently pregnant
- ☐ Currently breastfeeding
- ☐ Other: _____

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Any heart trouble
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling in legs
- ☐ Exercise intolerance

Musculoskeletal
- ☐ Joint pain/stiffness
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Bulging discs of the back or neck
- ☐ Back/neck surgery
- ☐ Significant arthritis
- ☐ Loss of mobility
- ☐ Fibromyalgia

Gastrointestinal
- ☐ Decreased appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Hepatitis
- ☐ Kidney disease

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Migraines
- ☐ Tingling
- ☐ Numbness
- ☐ Blackouts
- ☐ Syncope
- ☐ Tremor
- ☐ Seizures
- ☐ Paralysis
- ☐ Stroke
- ☐ Memory loss
- ☐ Confusion
- ☐ Meningitis
- ☐ Peripheral neuropathy
- ☐ Parkinson's disease
- ☐ Multiple sclerosis

Psychiatric
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Loss of motivation
- ☐ Suicidal ideation
- ☐ Nervous breakdown

Respiratory
- ☐ Shortness of breath
- ☐ Tuberculosis

Endocrine
- ☐ Hypo-thyroidism
- ☐ Hyper-thyroidism
- ☐ Increased thirst
- ☐ Increased hunger
- ☐ Increase urination
- ☐ Diabetes
- ☐ Hormone therapy
- ☐ Hypoglycemia

Hematologic
- ☐ Enlarged lymph nodes
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Previous transfusions

Immunologic
- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Increased infections
- ☐ Autoimmune disorders
- ☐ Sexual transmitted diseases
- ☐ HIV exposure
- ☐ HIV positive
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Allery to latex
- ☐ Allergy to adhesive

G. Family History: Select the following diseases which are common in your family or have occurred in any family member. Do not include family members by marriage or adoption.

- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding disorders
- ☐ Multiple sclerosis
- ☐ Dizziness
- ☐ Diabetes
- ☐ Hay fever
- ☐ Hearing loss
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Meniere's disease
- ☐ Migraine
- ☐ Surgical complications
- ☐ Parkinson's disease
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ Stroke
- ☐ Cancer

H. Medication History: Have you ever taken any of the following drugs? Please select all that apply.

- ☐ Aspirin in large doses
- ☐ Quinidine (for malaria)
- ☐ Cisplatin (for cancer)
- ☐ Streptomycin (antibiotic)
- ☐ Furosemide (Lasix)
- ☐ Tamoxifen (to prevent breast cancer)
- ☐ Gentamicin (antibiotic)
- ☐ Tobramycin (antibiotic)
- ☐ Kanamycin (antibiotic)
- ☐ Vancomycin (antibiotic)
- ☐ Procardia (for blood pressure)

General/Constitutional

Yes No 1. Have you ever received radiation to the head or neck?

Yes No 2. Do you have untreated diabetes?

Dizziness Handicap Inventory

Name: _____ Date Completed: _____

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

For Office Use Only: Total: _____ _____ = _____

Patient Demographic Information Form

Last Name: _____ First Name: _____MI: _____

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: _____-_____-_____ Sex: ____
Language: **ENGLISH SPANISH OTHER**: _____ DOB: _____
Ethnicity: **HISPANIC OR LATINO NON-HISPANIC OR LATINO OTHER**: _____
Race: **AFRICAN AMERICAN BOSNIAN CAUCASION HISPANIC OTHER**: _____
Emergency Contact: _____ ER Contact Phone #: _____
Patient Home #: _____ Work #: _____ Cell #: _____
Preferred Phone #: **HOME WORK CELL** Email Address: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Primary Care Doctor: _____ Referring Doctor: _____

Insurance Information:

Primary Insurance: _____ Claims Address: _____
Insured ID #: _____ Group #:_____ Copay: _____
Subscriber's Name (if different than above): _____
Subscriber's Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____Work #: _____ Cell #: _____
Subscriber's DOB: _____ Subscriber's SS#: _____-_____-_____ Sex: ____

Secondary Information:

Secondary Insurance: _____ Claims Address: _____
Insured ID #: _____ Group #:_____ Copay: _____
Subscriber's Name (if different than above): _____
Subscriber's Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____Work #: _____ Cell #: _____
Subscriber's DOB: _____ Subscriber's SS#: _____-_____-_____ Sex: ____

Responsible Party Information:

Last Name: _____ First Name: _____MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Cell #: _____
DOB: _____ SS#: _____-____-_____ Relationship to Patient: _____ Sex: ____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth:_____

I understand that Midwest Dizziness and Balance Institute (the "Practice") has certain rights and obligations regarding my protected health information. I also understand that I have certain rights about my protected health information.

I authorize the Practice to provide reminders regarding upcoming appointments I may have to me, or anyone who may answer the telephone, and/or to leave reminders on any telephone answering device I have provided to the Practice.

I authorize MDBI to report any test results on any telephone answering device or service which may answer the telephone number I inserted in the preceding paragraph.

I authorize the Practice to disclose my protected health information to any of the following persons (state name and relationship):

Name: _____ Phone #: _____ Relationship (circle one): spouse parent child friend

Name: _____ Phone #: _____ Relationship (circle one): spouse parent child friend

Name: _____ Phone #: _____ Relationship (circle one): spouse parent child friend

Name: _____ Phone #: _____ Relationship (circle one): spouse parent child friend

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing. I acknowledge receipt of the Practice's Privacy Practices Notice effective April 1, 2020 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations, or further information regarding The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official

Midwest Dizziness and Balance Institute

Attn: Jaime Carmody
12380 Olive Blvd
Creve Coeur, MO 63141

Signature of patient/ Patient Representative: _____ Date: _____

Basis of Representative's authority to act for Patient: _____

Patient's Medical Records Release Authorization

I authorize the use or disclosure of the below named individual's health information as described below.

Patient Name:_____**DOB:**_____

Address:_____

Telephone Number (circle one: home cell work)_____

The following individual or organization is authorized to make the disclosure on my behalf.

The type of information to be used to disclosed is as follows – please check the appropriate boxes and include any other information:

☐ Office Visit Notes ☐ Testing ☐ Entire MDBI Record

The information identified above may be used by or disclosed to the following individuals, organizations, or doctor's office:

1. **Name**_____ **Office Phone #**_____

   Address_____ **Fax #**_____

2. **Name**_____ **Office Phone #**_____

   Address_____ **Fax #**_____

3. **Name**_____ **Office Phone #**_____

   Address_____ **Fax #**_____

4. **Name**_____ **Office Phone #**_____

   Address_____ **Fax #**_____

The information for which I am authorizing disclosure will be used for the following purposes:

☐ My Personal Records ☐ Sharing with other health care providers ☐ Other

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that by signing this form, I am confirming my authorization for use and or disclosure of the protected health information described in this form with the people and or organizations named in this form.

Patient Name (please print) _____

Patient Signature_____ **Date** _____

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTCOPY YOUR INSURANCE CARD(S) AND A PHOTO ID FOR YOUR FILE.

APPOINTMENTS – 48-hour notice must be provided in the even you cannot keep an appointment. Should you not provide this notice, a cancellation fee for BPPV, ECochG, AVT $35.00 first/$50.00 for the second and thereafter. A Full Eval is $150.00 cancellation fee.

REFFERALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it in our office at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

CO-PAYMENTS – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5.00 may be added to your account. Any procedure performed in this office should be deemed medical by your insurance company and all copays and deductibles will apply.

FMLA AND/OR WORKMANS COMP – There is a $25.00 charge for completion of Workman's Comp, FMLA, and any other request for forms to be completed by our staff.

DEPOSITS – If our office determines that your course of care requires a deposit to hold an appointment, it will be collected at time of scheduling.

IN/OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office. (**Private Insurance authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Midwest Dizziness and Balance Institute for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.**)

SELF-PAY PATIENTS – Payments is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE – We submit claims to Medicare. The patient will be responsible for the deductible and 20% co-insurance, which can be billed to a secondary insurance. (**Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits to be made on my behalf to Midwest Dizziness and Balance Institute for any services furnished to me. I authorize any hold of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.**)

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Midwest Dizziness and Balance Institute will not be involved with separation or divorced disputes.
INSUFFICIENT FUNDS CHECKS – A $25.00 fee will be charged to patient's account for checks returned due to non-sufficient funds.

You are responsible for the timely payment of your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient Name: _____ Date: _____

Responsible Party: _____ Date: _____

NO SHOW FEE & CANCELLATION POLICY

Please be advised that effective immediately, failure to give a 48-hour notice prior to your appointment or **NO SHOWING/ CANCELLING** an appointment will result in a charge as follows:

- **Full Evaluation: $150**
- **BPPV Maneuver/Epley Triax/ECochG: $50**
- **AVT: $35 (1st)**
  $50 (2nd and each time after)

This charge cannot be billed to the insurance company. Failure to pay a no show/cancellation fee will be treated according to our policy on unpaid balance. Failure to pay fees or re-current no shows may result in discontinuation of your treatment.

Please Note: FEE WILL ONLY BE WAIVED IN CASE OF EMERGENCY LIKE; DEATH IN THE FAMILY, HOSPITAL ADMISSION, ILLNESS, ETC., BUT PROOF HAS TO BE PROVIDED.

I have read and understand the above & a copy will be provided upon request:

Patient Name (please print) _____

Patient Signature_____ Date _____