WELCOME

The benefits of hearing are immeasurable. Our primary goal is to provide you with the very best personalized hearing care. We will work with you until you are satisfied with your hearing abilities. Gulf Coast Audiology is dedicated to serving your needs in an honest and attentive manner.

PATIENT INFORMATION

DATE _____

PATIENT NAME _____

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

E-MAIL ADDRESS _____

STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOW ☐ DIVORCED ☐ CHILD

EMPLOYED ☐ YES ☐ NO EMPLOYER _____

EMPLOYER'S ADDRESS _____
STREET CITY STATE ZIP CODE

EMPLOYER'S PHONE _____

CONTACT PERSON *(OTHER THAN PATIENT)* ☐ SPOUSE ☐ RELATIVE ☐ FRIEND ☐ GUARDIAN

NAME _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____
STREET CITY STATE ZIP CODE

TELEPHONE _____

ARE YOU A SEASONAL RESIDENT? ☐ YES ☐ NO

FLORIDA SEASONAL DATES: FROM _____ UNTIL _____

ALTERNATE ADDRESS _____
STREET CITY STATE ZIP CODE

ALTERNATE TELEPHONE _____

OVER

INSURANCE VERIFICATION FORM

Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

Effective Date_____

Spouse/Family Member Policy Holder Name_____DOB_____Relation To Patient_____
(If Other Than Patient)

Insurance Company_____ID#_____ GRP#_____

Claims Mailing Address:_____ Ins Co. Phone:_____

Deductible? Yes__ No___ How Much?_____Has Deductible Been Met_____If Not How Much Left?_____

Co-Pay? Yes__No__ How Much?_____In Network?_____Out Of Network_____

Are We A Participating Provider?_____Our Provider #_____

Hearing Aid Coverage?___Yes___No___If So How Much?_____How Often?_____

Does Patient Need To Be Referred By ENT?_____Primary Care Doctor?_____

Hearing Testing Benefits?_____Does Deductible Apply?_____ Co-Pay_____

SIGNATURE ON FILE AND AUTHORIZATION

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN TODAY IS CORR ECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILTY TO INFORM THIS OFFICE OF ANY CHANGES.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL FEES CHARGED BY GULF COAST AUDIOLOGY, FOR SERVICES AND PRODUCTS. I UNDERSTAND THAT FEES ARE PAYABLE UPON RECEIPT OF SERVICES UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I AUTHORIZE THE AUDIOLOGY STAFF TOPERFORM ANY NECESSARY AUDIOLOGICAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH INFORMED CONSENT.

I AUTHORIZE PAYMENT OF INSURANCE/MEDICARE BENEFITS TO THE UNDERSIGNED AUDIOLOGIST FOR SERVICES RENDERED, DR. DRIANIS DURAN, AuD. GULF COAST AUDIOLOGY.

I AUTHORIZE GULF COAST AUDIOLOGY TO RELEASE TO MY INSURANCE COMPANY AND/OR THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

_____ _____

PATIENT SIGNATURE DATE

Drianis Duran, Au.D.
Board Certified Audiologist

VNG INSTRUCTIONS

Certain medications or substances can influence the body's response to the test, giving a useless or even false result**.**
Please continue to take heart, high blood pressure, antidepressant, and anticonvulsant medications.

In preparation for the examination, we ask that you follow the instructions listed below:

- Do ***not*** drink coffee, tea, soda or any beverage containing caffeine within 24 hours of the evaluation.
- Do ***not*** eat or smoke for 3 hours before the evaluation.
  However, if you are diabetic, you may eat a light meal.

Discontinue the use of the following, 2 days (48 hours) prior to the evaluation:

- Aspirin
- Alcohol in any quantity: Including beer, wine and cough medicines containing alcohol
- Anti-nausea medication: Dramamine, Compazine, Phernergan, Bonine, etc.
- Anti-vertigo medication: Antivert, Meclizine, etc.
- Antihistamines or any over-the-counter cold remedies.

The test will take about 1 to 1 ½ hours.

- **We ask that women do not wear any eye makeup on the day of the test.**
- Please dress comfortably.
- We would appreciate if you would bring a list of the medications you are currently taking.

BALANCE TESTING

Videonystagmography (VNG) is a test of your balance system. The VNG evaluation is the recording of nystagmus or eye jerks by a camera. There are neural connections that stretch from the balance mechanism in the inner ear to the muscles of the eye. A disorder of the balance mechanism results in small eye jerks that can only be detected by a sophisticated computer. A camera attached to a pair of goggles records these eye jerks during a series of tasks. The balance mechanism is monitored during tasks that consist of looking back and forth between designated points, following moving lights, lying in different positions, shaking your head, and lying down and sitting up quickly. The final portion of the test requires putting cool and/or warm air in the ear canal for roughly 60 seconds in order to determine if the balance mechanism of each ear can increase and decrease normally in response to stimulation. Some individuals become dizzy for 2-5 minutes, but most are able to drive home after the test without difficulty. If you are concerned about not being able to drive afterwards, please arrange for someone to transport you.

DIZZINESS QUESTIONNAIRE

Name: _____ Date of Testing_____

Referring Physician: _____ Primary Complaint_____

- **In your own words, please describe your dizziness/lightheadedness/vertigo:**

_____
_____
_____

- **When did this first begin?_____**
- **Do you experience the problem constantly or in attacks? (please circle)**
- **How often does it occur?_____**
- **How long does it last?_____**
- **If your dizziness occurs in attacks, do you have any warning that the attack is about to start?**

_____
_____

- **Do you know of a possible cause of your dizziness? Please describe:_____**

_____

- **Do you know of anything that will: (please circle)**
  - **Stop your dizziness or make it better? YES NO**
  - **Make your dizziness worse? YES NO**
  - **Precipitate an attack? YES NO**

  Please describe:_____

  _____

- **Does your "dizziness" occur only in certain positions? If so, please describe:_____**

_____

When you are "dizzy", do you experience any of the following sensations? Before answering, please read the entire list. Simply circle YES or No to the sensation that best describes what you are feeling:

1. **Lightheadedness YES NO**
2. **"Swimming" Sensation in your head YES NO**
3. **Objects spinning around you YES NO**
4. **Sensation that you are turning or spinning inside, with outside objects remaining stationary YES NO**
5. **Blacking Out YES NO**

6. **Loss of Consciousness.** YES NO
7. **Tendency to fall: To the Right?** YES NO
   To the Left? YES NO
   Forward? YES NO
   Backward? YES NO
8. **Loss of balance when walking: Veering to the *right?*** YES NO
   left? YES NO
9. **Headache?** YES NO
10. **Nausea or vomiting?** YES NO
11. **Pressure in your head?** YES NO

PLEASE CIRCLE YES OR NO AND FILL IN THE BLANKS:

1. **Do you have trouble walking in the dark?** YES NO
2. **Do you have any allergies?** YES NO
3. **Did you ever have a head injury?** YES NO
   - **Were you unconscious?** YES NO

4. **Do you use tobacco?** YES NO
   - **How Much?**_____
5. **Do you use alcohol?** YES NO
   - **How much?**_____

6. **Do you use recreational drugs?** YES NO
   - **How often?**_____

7. **Do you take prescription medications?** YES NO
   - **Please list the medications you take on a regular basis:**_____
   _____
   _____
   _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR EARS AND HEARING: SIMPLY CIRCLE YES OR NO

1. **Difficulty hearing?** YES NO
   - **If so, please circle: Right Left Both Ears**
   - When did you first notice the hearing loss?_____

2. **Ringing or noise in your ears?** YES NO
   - **If so please circle: Right Left Both Ears**
   - Describe the noise:_____
   _____
   - **Does the noise change with dizziness? Please describe:**_____

_____

■ Does anything stop the noise or make it better? Please describe:_____

_____

3. Fullness in your ears? YES NO

▪ If so, please circle: RIGHT LEFT BOTH EARS

▪ Does this change when you are dizzy? Please describe_____

_____

4. Pain in your ears? YES NO

▪ If so, please circle: RIGHT LEFT BOTH EARS

5. Discharge from your ears? YES NO

▪ If so please circle: RIGHT LEFT BOTH EARS

6. Have you ever had ear surgery? YES NO

▪ If so, please describe:_____

_____

PLEASE CIRCLE YES OR NO IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS:

1. **Double Vision YES NO**
2. **Blurred Vision or Blindness YES NO**
3. **Spots before your eyes YES NO**
4. **Confusion or loss of consciousness YES NO**
5. **Weakness in arms or legs YES NO**
6. **Numbness of your face or extremities YES NO**

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

1. **Did you get new glasses recently? YES NO**
2. **Do you get dizzy when you have not eaten for a long time? YES NO**
3. **Have you ever had a neck or back injury? YES NO**
4. **Are you exposed to any irritating fumes, paints, solvents, etc? YES NO**

▪ If yes please describe:_____

_____

PLEASE LIST, AND/OR DESCRIBE ANY GENERAL HEALTH PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR:

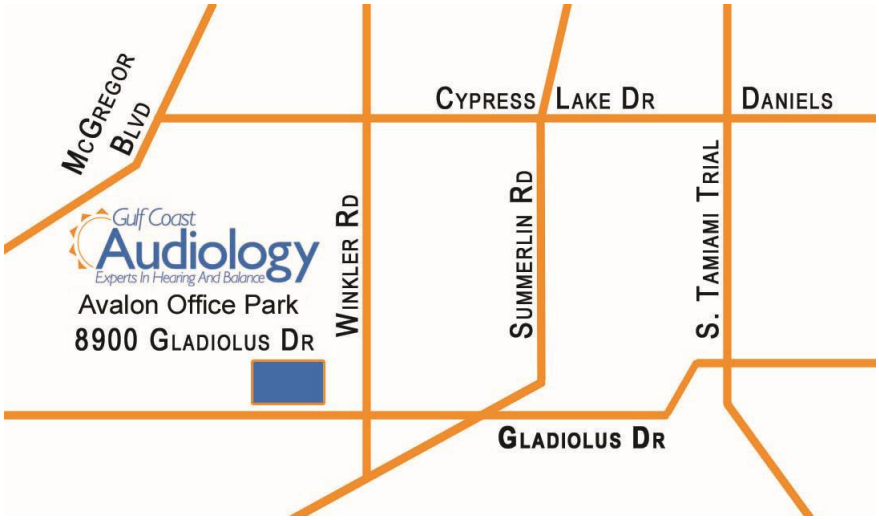
_____

_____

_____

_____

Map & Directions



Park on the left side of building. We are on the second floor in Suite 201. The elevator is located adjacent to the stairs for your convenience.

From McGregor:
Turn onto Gladiolus Dr. and head east. Drive past Bass Rd. and Parker Lakes Dr. Turn left into the Avalon Office Park

From Summerlin:
Turn onto Gladiolus Dr. and head west. Drive just past Winkler Rd. and turn right into the Avalon Office Park.

From 41:
Turn onto Gladiolus Dr. and head west. Drive just past Winkler Rd. and turn right into the Avalon Office Park.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Gulf Coast Audiology
8900 Gladiolus Drive, Suite 201
Fort Myers, Florida 33908
Telephone: 239-267-7888
Fax: 239-267-0409

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my Audiologist's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices.*** I understand that my Audiologist has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____
(If Applicable)

.....

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other