ADULT AUDIOLOGY INFORMATION PACKET
DIAGNOSTIC EVALUATION

Cover letter
Driving Directions to CSHC
Diagnostic Vestibular Testing
Balance Testing Preparation
Dizzy Questionnaire
If you intend to seek insurance reimbursement
Patient Intake & Insurance Information
Case History Form
Consent to Treat

FOR MEDICARE PATIENTS ONLY:
Medicare regulations governing outpatient rehabilitation services
Determining if Medicare is the primary payor

In order to be able to properly complete, save and resend, please adhere to the following steps:

1. Download and save to your computer 1st

2. Reopen the document and complete form

3. Save and then attach in an email to Chris Weik cweik@cshcga.com.

4. *Print your name in signature blocks. Upon arrival at CSHC you will be asked to sign where needed.

In order to have a diagnostic appointment schedule, please either: 1) complete and email these forms to Chris Weik @ cweik@cshcga.com, 2) hand deliver to our office, or 3) mail them back via USPS. Upon receipt, and review, someone from our office will contact you to schedule an appointment. Thanks in advance for completing these forms, we look forward to seeing you in our office.

Columbus Speech & Hearing Center
2424 Double Churches Road
Columbus, Georgia 31909
(706) 324-6112 / (706) 596-8259 fax

To whom it may concern:

Your physician has referred you to Columbus Speech & Hearing Center for a hearing evaluation and/or balance evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call _____
- Text – give us the number to text _____
- EMAIL – give us your email address _____
- Please tell us when it is best to contact you _____

- Text – **Opt in for TEXT reminders to avoid no-show and late fees.** **TEXT CSHC to 622622**
  - ☐ I have opted in for TEXT reminders to be sent to this cell number _____
  - ☐ I do not want TEXT reminders

If you have questions about scheduling, contact Dawn Fernandez at 706-324-6112, extension 204. Feel free to leave Dawn a voice message if she is not available.

Please note that once the evaluation appointment is scheduled this time is dedicated just for you. If you need to cancel or change the appointment, please contact us 48 hours prior to the appointment to avoid a $50.00 rescheduling fee.

We look forward to seeing you soon.

Chris Weik
Front Office Supervisor
cweik@cshcga.com 706-324-6112 extension 230

Enclosed forms for your general information:

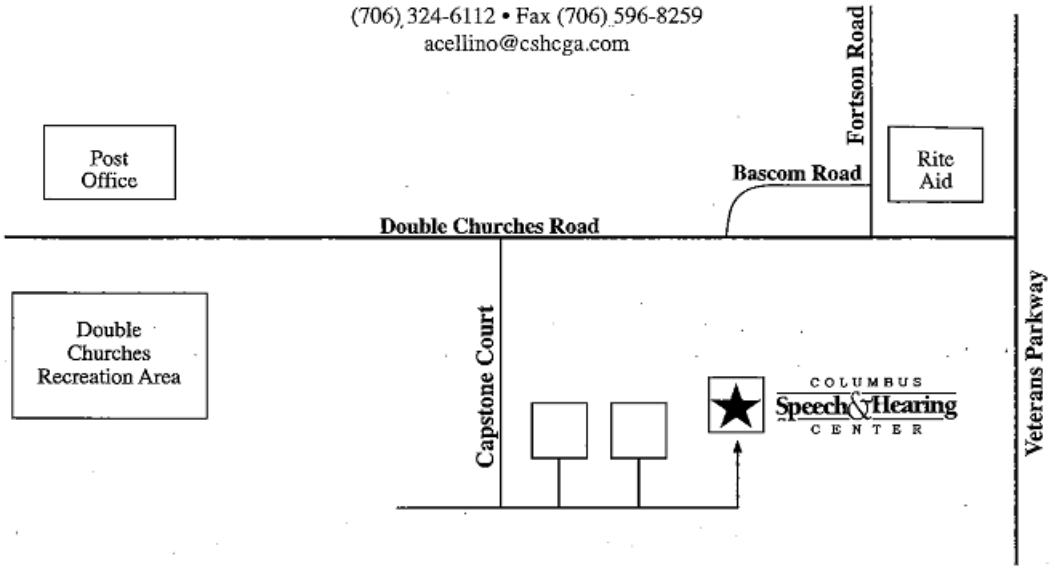
1. *This Cover Letter*
2. *Driving directions to Columbus Speech & Hearing Center*
3. *Diagnostic Vestibular Testing information sheet/Balance testing preparation*
4. *If You Intend to Seek Insurance Reimbursement*

Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:

1. *Dizzy Questionaire*
2. *Adult patient intake and insurance information form*
3. *Adult Audiology Case History Form*
4. *Consent to Treat*
5. *Medicare only: Medicare regulations governing outpatient rehabilitation services*
6. *Medicare only: Determining if Medicare is the primary payor*

Directions to Columbus Speech & Hearing Center

COLUMBUS
Speech & Hearing
CENTER
2424 Double Churches Road • Columbus, GA 31909
(706) 324-6112 • Fax (706) 596-8259
acellino@cshcga.com



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left

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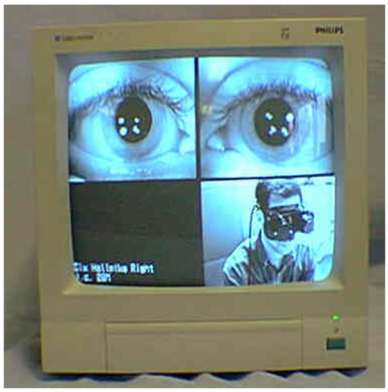
Diagnostic Vestibular Testing for Dizzy Patients

Columbus Speech & Hearing Center now provides **videonystagmography** (VNG) testing. VNG testing allows our audiologists to assess problems of dizziness and balance through a battery of tests. During testing, video goggles with infrared cameras record the eye movements of the patient, revealing abnormalities in the balance system.

Previously, eye movement was recorded using electrodes placed on the face around the eyes, known as **electronystagmography** (ENG). Advances in technology have given the VNG several key advantages over the ENG. The use of infrared goggles during VNG testing eliminates confounding physical and environmental noises that confound results obtained with ENG surface electrodes. This allows for a "cleaner" tracing, which is more easily interpreted. The data tracings, normative data and statistical analysis can be sent to the physician for a comprehensive diagnostic picture of the patient's balance problems.



Testing typically takes place in a ninety minute appointment. First, a thorough case history is taken to better understand the patient's symptoms. During the test session, a diagnostic audiological evaluation is performed to assess the functioning of seven main tests: gaze, saccades, horizontal tracking, optokinetic nystagmus, positional, Dix-Hallpike maneuvers, and calorics.

- **Spontaneous Gaze/Nystagmus Test**
  The Spontaneous Gaze/Nystagmus Test is designed to determine if a patient's eye-motor system, or the specific reflexes between the inner ear and the eye, is normal. The first portion of this test is performed by having the patient track a moving target by only moving their eyes. During the second portion of the test, the patient holds their eyes on a target while moving their head in a specific pattern. The third portion of this test is performed by evaluating a patient's ability to hold their eyes straight forward when their eyes are shut.

- **Saccade Test**
  The Saccade Test is designed to observe the velocity, accuracy, and latency of rapid eye movements from one target to another.

- **Optokinetic Nystagmus Test**
  The Optokinetic Nystagmus test evaluates a patient's ability to track moving objects with their eyes. This test evaluates functions of the brain to determine if this damage may cause an abnormal influence on the balance systems and the brainstem.

- **Bithermal Caloric Testing**
  The Bithermal Caloric Testing exam is used to determine if one ear has a weaker balance canal than the other, or if both sides have an impaired response causing dizziness or imbalance. The test is administered with the patient in a reclining position. Each ear canal is alternately irrigated with cool and warm air for 60 seconds, which causes the lateral semicircular canal of the inner ear to be stimulated. The stimulation normally results in beating eye movements called nystagmus, which occur since the brain is tricked into thinking the patient is rotating. The responses of the balance mechanism are calculated through the strength of the beating eye movements (nystagmus).

- **Positional Testing**
  The Positional Test is used to evaluate the balance system by recording the patient's eye movements as they are placed in certain positions and/or moved into different positions. These tests aid the physician in determining the stability of the balance system as it adapts to new positions. This test is also useful in identifying signs of benign paroxysmal positional vertigo (BPPV), one of the more common types of vertigo.

The audiologist may also work with the physician, otolaryngologist or other professionals to develop and direct individual vestibular rehabilitation programs. There are several types of vestibular disorders that may be helped by vestibular rehabilitation.

Please contact me if you have any suggestions on how we may better serve your patients receiving VNG assessments. We want our services to be coordinated with your and seamless for the patients. As always, we appreciate your support.

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Balance Testing Preparation

Patient: _____ Appointment date: _____ Time: _____

You have been scheduled for a test of your balance mechanism. The examination is a simple, painless procedure requiring about an hour. The test will involve moving the head and body into different positions, as well as stimulating the ears with cool and warm water. If you have any problems with your neck or back, please inform us prior to the beginning of the evaluation. This test will likely cause some dizziness that generally passes within a few minutes. In rare instances, the dizziness lasts a little longer, making it inadvisable to drive for a short time. You should make arrangements for someone to be available to come drive you home in the event you are unable to do so. Instructions below are intended to prepare you for the testing so you will be as comfortable as possible, and to avoid anything that may interfere with the test results. Please read them carefully. Call our audiologists (706-327-7592) if you have questions.

☐ It is imperative that you ***DO NOT*** take any anti-vertigo and anti-dizziness medications for 48 hours (2 days) prior to testing. These medications include Antivert, Meclizine, Bonine, Dramamine, Scopolamine and antihistamines – both over the counter and prescription forms of these medications.

☐ Please ***DO NOT*** discontinue any prescription medication without checking with the physician who prescribed it. If you cannot go without a medication listed above, please call one of our audiologists at (706) 327-7592 to discuss this prior to coming to the evaluation.

☐ Abstain from alcohol for 48 hours before testing. ***All*** alcoholic beverages affect the results of this test.

☐ No eating drinking, or smoking for 3 hours prior to the time of your appointment.

☐ ***Do not*** wear any eye make-up, including eyeliner or mascara.

Please dress comfortably. Women may wish to wear slacks. If you wear contact lenses, please bring your glasses with you in case you need to remove your lenses. You may also wish to bring your eyeglass holder.

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Patient Name: _____ **Birthdate:** _____

Referral Source: _____ **Test Date:** _____

DIZZY QUESTIONAIRE

Check all that apply

DOES DIZZINESS FEEL LIKE

- ☐ Motion
  - ☐ Spinning
  - ☐ Turning
  - ☐ Falling
    - ☐ Left
    - ☐ Right
    - ☐ Forward
    - ☐ Backward
- ☐ Lightheaded
- ☐ Faintness
- ☐ Wooziness
- ☐ Tilting/swaying
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Falling
- ☐ Shortness of breath
- ☐ _____
  _____
  _____
  _____

ASSOCIATED EAR SYMPTOMS

SYMPTOMS
- ☐ Ringing in ears
- ☐ Popping in ears
- ☐ Fullness or pressure
- ☐ Hearing loss

WHICH EAR
- ☐ Right
- ☐ Left
- ☐ Both

OTHER ASSOCIATED SYMPTOMS
- ☐ Nausea/vomiting
- ☐ Headache
- ☐ Loss of consciousness
- ☐ Weakness or numbness of arms, legs or face
- ☐ Visual disturbance
  - o Wear glasses?
  - o Wear contacts?
- ☐ Difficulty with speech

TIME PERIOD

First time I was dizzy _____

How often?

How long does it last?
_____sec _____min

_____hrs _____days

Last episode?

- ☐ Warning before attack starts
- ☐ Free of dizziness between attacks
- ☐ Time of day
  - ☐ Morning
  - ☐ Afternoon
  - ☐ Evening
  - ☐ Bedtime
  - ☐ Awaken from sleep

PAST HISTORY

- ☐ Head injury
- ☐ Ear injury
  - ☐ Left Right
- ☐ Scuba diving
- ☐ Ear surgery
  /_/ Left Right
- ☐ Sinus trouble
- ☐ Allergies
- ☐ Stroke
- ☐ Diabetes
- ☐ Abnormal heart beat
- ☐ Heart disease
- ☐ Circulation problem
- ☐ Thyroid disease
- ☐ Neck pain
- ☐ Back pain
- ☐ Whiplash

PREVIOUS TESTS
- ☐ MRI
- ☐ Head CT

Results: _____
_____

What improves your dizziness?

- ☐ Eyes closed
- ☐ Eyes open
- ☐ Lying down
- ☐ Medication
  _____
- ☐ Other
  _____
  _____
  _____

MEDICATIONS/DRUGS

- ☐ Caffeine
- ☐ Alcohol
- ☐ Tobacco
- ☐ Nerve medicine
- ☐ Sedatives
- ☐ Other: _____
  _____
  _____
  _____
  _____

What makes your dizziness worse?

- ☐ Head movements
- ☐ Getting up from sitting or lying position
- ☐ Fatigue
- ☐ Hunger
- ☐ Exertion
- ☐ Menstrual period
- ☐ Stress
- ☐ Irritating fumes
- ☐ Position
- ☐ Other _____

IF YOU INTEND TO SEEK INSURANCE REIMBURSEMENT

Columbus Speech & Hearing Center is an approved provider for multiple insurance companies. You should know that insurance companies frequently list speech therapy, audiology, and occupational therapy as reimbursable services, but that is not a guarantee of payment, particularly if the disorder is not due to a "medical" condition. Before your first visit, our staff will contact your insurance company and determine if the diagnostic evaluation is covered, if you have related deductible or co-pay. We will share that information with you before your visit here.

Before your first visit, we need:

1. Your physician to send us a prescription for a speech, language, occupation, balance and/or hearing evaluation. These scripts are faxed to our office (Fax: 706-596-8259)
2. A copy of your insurance card, front and back, if that presents a problem you may provide that at your appointment
3. A completed *Patient Intake and Insurance Information* form, which is enclosed

If therapy is needed and you intend to seek insurance reimbursement:

1. Insurance companies typically require a written Diagnostic Evaluation, which we provide with a request for prior authorization of therapy. We notify you of their response before therapy starts.
2. Insurance companies may require periodic (usually on 6 month intervals) re-evaluations with progress reports. These entail additional reports, updated treatment plans, and staff time. Applicable fees are charged to the patient as "Additional services".
3. In general, we cannot negotiate with your insurance company on your behalf. In case of denials, we will provide any information they request, such as diagnostic reports or daily treatment notes. Will share all knowledge we have of what triggered the denial. If it is due to clerical error on our part, we will correct those errors and resubmit the claim. If it is due to the insurance company's coverage restrictions, we cannot negotiate with them on your behalf.
4. You are ultimately responsible for payment in full for any professional services rendered, regardless of your insurance status. Understand that prior authorization for a procedure is not always a guarantee of payment by the insurance company.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me.

s/s_____ _____

*Patient/Guardian signature indicating receipt and understanding of information above Date

Columbus Speech & Hearing Center
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ADULT PATIENT INTAKE AND INSURANCE INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE

PRIMARY CARE PHYSICIAN	SOCIAL SECURITY NUMBER	SEX

ADDRESS:
OCCUPATION:
EMPLOYER:
HOME PHONE: CELL PHONE: WORK PHONE:
EMAIL:

INSURANCE IDENTIFYING INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE		
NAME OF POLICY HOLDER		
RELATIONSHIP TO PATIENT		
POLICY NUMBER		
GROUP NUMBER		
PROVIDER CUSTOMER SERVICE NUMBER		
PLAN TYPE: HMO, POS, PPO		

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me

*s/s*_____ _____

Name *Date*

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Adult Audiology Case History

Name_____ Birthdate_____Today's Date:_____
How did you hear about us?_____Name of spouse or friend with you today?_____
Referral source: _____To whom should reports go: _____

Check any of the following that you currently have, or have had:					
High blood pressure		Heart disease		Stroke	
Arthritis		Diabetes		Kidney disease	
Cancer		Mumps		Measles	
Meningitis		General anesthetic		Head Trauma	

1. List any chronic illnesses: _____
2. List all current medications: _____
3. How is your current health? _____
4. Was the onset of your hearing loss sudden or gradual? _____
5. Who first noticed your hearing problem?_____When?_____
6. Describe any medical treatment you may have had for your hearing problem: _____
7. In which ear do you hear better? Left Right

8. Do you have tinnitus (ringing, buzzing, hissing) sounds in your ear? Yes_____ No_____
9. In which ear does it occur? Left_____ Right_____ Both_____
10. When did you first notice it? 1-3 years_____ 4-10 years_____ More than 10 years_____
11. How often does your tinnitus occur? _____
12. When was the last time you had your hearing tested? _____ Where? _____
13. Why have you decided to have your hearing tested at this time?
    - ☐ a. I feel my hearing is poor and may need to be aided
    - ☐ b. Family/friends have suggested I have my hearing tested.
    - ☐ c. Other/explain:
14. If you wear hearing aids:
    a. In which ear? Left only_____ Right only_____ Both ears_____
    b. When did you buy your hearing aids?_____
    c. Approximately how many hours a day do you wear them? _____
    d. Do you have any problems with your aids? _____ If Yes, explain: _____

Yes	No	***Please check yes or no. For "Yes" answers to the following questions, please explain***
☐	☐	*Have you been exposed to loud noise for long periods of time?*
☐	☐	*Does anyone in your family have hearing loss?*
☐	☐	*Do you have dizziness, vertigo or loss of balance?*
☐	☐	*Have you ever worn a hearing aid?*
☐	☐	*Did you have chronic ear infections as a child or adult?*
☐	☐	*Do your ear canals itch?*
☐	☐	*Have you had any falls within the last 12 months? If so how many?*
☐	☐	*Do you use tobacco products? If so how often?*
☐	☐	*Do you have tubes or holes in your eardrum?*
☐	☐	*Do you have sinus or allergy problems?*
☐	☐	*Do you have pain or discomfort in your ears?*
		Do you have difficulty when:
☐	☐	*a. Someone speaks in a whisper?*
☐	☐	*b. Visiting friends, relatives or neighbors?*
☐	☐	*c. Listening to TV or radio?*
☐	☐	*d. Listening to children or women?*

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CONSENT TO TREAT SIGNATURE PAGE

Patient Name: DOB: Age: Account:

Instructions: Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			CONSENT FOR TREATMENT: I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, *I accept personal liability for the charges not reimbursed by Insurance within 45 days.*
			AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of relevant diagnostic, therapy , or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* (you may refuse to sign this acknowledgement) I have received a copy of this office's *Notice of Privacy Practices.*

I do hereby verify that this electronic signature (s) is authentic (where applicable), and the information herein is being submitted by me

s/s_____ _____ _____

Patient Name Date Witness

MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cannot bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

_____ _____ _____ _____

Patient Name Date *Parent/Guardian Signature Witness

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

Rev 2-5-2020

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(706) 324-6112 / (706) 596-8259 fax

MEDICARE REGULATIONS GOVERNING OUTPATIENT REHABILITATION SERVICES

To insure maximum coverage for your speech and hearing rehabilitation and avoid any misunderstandings, there are several ***Medicare Regulations*** of which you should be aware.

- Medicare has an annual cash deductible of $198.00 which must be met before your coverage is effective. If this amount is paid during the last three months of the year, the amount paid during that period will be carried forward and applied to the up-coming year's deductible amount.
- Medicare outpatient coverage is 80% of reasonable charges. You are responsible for paying the other 20%. For children under 21 years of age who qualify for Medicaid, the 20% co-insurance portion is paid by Medicaid. Secondary insurance policies may pay the 20% co-pay. This should be confirmed in advance with our billing department.
- You (Medicare patient) can be accepted for outpatient speech pathology therapy, or audiological testing, or occupational therapy only on the written referral of your physician.
- Your attending physician will receive a copy of your initial evaluation report and Plan of Care within 10 days of your initial visit here.
- Subsequent Updated Plans of Care are forwarded to your attending physician every 30 days.
- Re-certification of continued need by the attending physician and therapist must be documented every 90 days.
- You must be under the care of your attending physician with his/her reports of his/her findings incorporated into your clinic file (speech, hearing, occupational therapy)
- Forms to be completed by your attending physician will be mailed to your doctor or given to you at the appropriate time.

To insure continued re-certification, your responsibilities are to:

1. Inform your physician of your desire to receive speech-language, audiology, or audiology services, thereby insuring his/her support.
2. Arrange for a regular check-up with your physician, hand carry your re-certification form to your physician. This will allow him/her to review your progress and re-certify your continued need for treatment. Return the above signed re-certification to your clinician at your next therapy visit.

I have read, understand, and agree to abide by the above regulations.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me

s/s_____ _____ _____ _____

*PATIENT SIGNATURE DATE WITNESS DATE

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FOR MEDICARE PATIENTS ONLY - DETERMINING IF MEDICARE IS THE PRIMARY PAYOR

QUESTION	NO	YES	
1. Is the patient 65 or older? 2. Is the patient employed? 3. Is the patient covered by an Employer's Group Health plan? 4. Does patient's employer have >100 employees?	_____ _____ _____ _____	_____ _____ _____ _____	If Yes to # 3, list the name, address and ID # on the card
1. Is the patient's spouse employed? 2. If YES, does the spouse have dependent coverage on his/her Group Health Insurance? 3. Does spouse's employer have 20 or more employees?	_____ _____ _____	_____ _____ _____	If Yes to # 2, list the name, address and ID # on the card
1. Is the patient a disabled Medicare beneficiary? 2. Is injury/illness due to a work related accident? 3. Is injury/illness due to an automobile or liability accident?	_____ _____ _____	_____ _____ _____	If Yes to # 3, explain
1. Does the patient suffer from kidney failure? 2. Does patient have Veterans' Administration benefit coverage? 3. Does patient have any other insurance coverage that will pay for therapy before Medicare e.g.COBRA?	_____ _____ _____	_____ _____ _____	If Yes to # 3, list the name, address and ID # on the card

By answering the preceding questions, I have established Medicare as the ☐ primary or ☐ secondary payor (check one). If Medicare is primary, I understand that I am responsible for any deductibles and coinsurance. If Medicare is secondary, I understand that Columbus Speech & Hearing Center will file my primary insurance before filing Medicare.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me

s/s_____ _____

*PATIENT SIGNATURE DATE