The American Institute of Balance®
Leading the World in Vestibular & Equilibrium Education

8200 Bryan Dairy Rd, Suite 340
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dizzy.com

Welcome to The American Institute of Balance

The Institute was founded in 1992 and is among the country's largest multi-specialty centers for the evaluation and treatment of dizziness and balance disorders. The Institute is nationally and internationally known for its expertise in evaluation, treatment and rehabilitation. The Institute's therapy programs are used by physicians, audiologists and therapists worldwide.

What to Expect at your Appointment?

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60 – 90 minutes.

Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions carefully:

1. Do bring your Photo ID, Insurance Card and List of Medications.

2. Do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the recordings.

3. Do not drink alcoholic beverages for 48 hours before the test.

4. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. Anti-vertigo medicines: Anti-vert, Ru-vert, or Meclizine; Anti-nausea medicine: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan, Thorazine, Scopalomine, Transdermal.

5. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.

6. Eat lightly the day of your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

7. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

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Patient Information

(incomplete forms will delay your appointment)

Name: _____ Middle: _____ Last: _____ ○ Male ○ Female

Address:_____ Apt/Unit: _____

City:_____ State:_____ Zip:_____

Phone #: _____ Cell #: _____ E-Mail: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____ Marital Status:

Emergency Contact: _____ Phone #:_____

Relationship:_____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? ○ Y ○ N

Name: _____ Phone #: _____

Primary Language: _____ Race: _____ Ethnicity: _____ For Appts Only Consent to Call Y N Text Y N

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

Employer:_____ Address:_____

Medical Doctor Information

Referring Physician:_____ Phone #: _____

Address:_____City:_____

State:_____ Zip: _____

Family Physician:_____ Phone #:_____

Please state briefly the nature of your problem: _____

Consent for Treatment

The patient/legal guardian authorizes 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.

Consent to Release Medical Information

I authorize AIB to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Cancellation/No Show Policy

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (less than 24 hours) will be charged a $75 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as patient.

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of AIB's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of AIB Privacy Practices is available to you upon request.

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.

Signature (Patient/Legal Guardian): _____ Date:_____

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

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Medical History

PATIENT NAME:_____

DATE:_____

Do you have, or have you had, any of the following?

Neurologic

- ☐ Migraine
- ☐ Stroke/TIA
  If so, when? _____
  ___
- ☐ Parkinson's Disease
- ☐ Seizures/ Epilepsy
- ☐ Concussion/Head Injury
  If so, when? _____
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic _____

Cardiovascular

- ☐ Heart Attack
  If so, when? _____
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other Cardiovascular_____

Respiratory

- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Other Respiratory _____

Other Health Issues

_____

_____

_____

_____

_____

Orthopedic

- ☐ Artificial Joints
  If yes, which? _____
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
  If so, when? _____
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Orthopedic_____

Vision

- ☐ Cataracts
  If removed, when? _____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision_____

Other

- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Tobacco Use
  If yes, how much? _____
- ☐ Alcohol Use
  If yes, how much? _____

continues on back >

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Medical History

PATIENT NAME:_____

DATE:_____

Please list all of your current medications and supplements

Presciption	Dosage	Frequency	Route	Reason

Over the Counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

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Patient Questionnaire

PATIENT NAME:_____

DATE:_____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

1. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? ☐ Parent ☐ Sibling ☐ Child
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Have you ever fallen? How many times? _____
		Where? _____ ☐ Inside the home ☐ Outside the home
☐	☐	Are you afraid of falling?

2. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (3).

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section 3.
☐	☐	If in attacks, how often? _____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____
☐	☐	Is the dizziness worse at any particular time of the day?
		If so, when?_____
☐	☐	Do you know of anything that will stop your dizziness or make it better?
		What?_____
☐	☐	_____ make your dizziness worse?
		What?_____
☐	☐	_____ precipitate an attack?
		What?_____
☐	☐	Do you know any possible cause of your dizziness?
		What? _____

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Patient Questionnaire

PATIENT NAME:_____

DATE:_____

3. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall..... to the right or left.
☐	☐	..... forward or backward
☐	☐	Loss of balance when walking..... veering to the right?
☐	☐	..... veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

4. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	☐ Constant	☐ In Episodes
☐	☐	Blurred vision or blindness?	☐ Constant	☐ In Episodes
☐	☐	Spots before your eyes?	☐ Constant	☐ In Episodes
☐	☐	Numbness of face, arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Weakness in arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Confusion or loss of consciousness?	☐ Constant	☐ In Episodes
☐	☐	Difficulty in swallowing? Tingling around the mouth?	☐ Constant	☐ In Episodes
☐	☐	Difficulty speaking?	☐ Constant	☐ In Episodes

5. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty in hearing?	☐ Both Ears	☐ Right Ear	☐ Left Ear
		When did this start? _____ Is it getting worse? _____			
		Does the hearing change with your symptoms? If so, how? _____			
☐	☐	Noise in your ears?	☐ Both Ears	☐ Right Ear	☐ Left Ear
		Describe the noise?			
		Does the noise change with your symptoms? If so, how? _____			
☐	☐	Does anything stop the noise or make it better? _____			
☐	☐	Fullness or stuffiness in your ears?	☐ Both Ears	☐ Right Ear	☐ Left Ear
		Does this change when you are dizzy? _____			
☐	☐	Pain in your ears?	☐ Both Ears	☐ Right Ear	☐ Left Ear
☐	☐	Discharge from your ears?	☐ Both Ears	☐ Right Ear	☐ Left Ear

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Patient Name: _____

Date: _____

Initial Visit / Follow-up / Discharge

The Dizziness Handicap Inventory (DHI)

PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS

		YES	SOMETIMES	NO
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or recreation?			
P4	Does walking down the aisle of a supermarket increase your problems?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?			
F7	Because of your problem, do you have difficulty reading?			
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
E9	Because of your problem, are you afraid to leave your home without having without having someone accompany you?			
E10	Because of your problem have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous homework or yard work?			
E15	Because of your problem, are you afraid people may think you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20	Because of your problem, are you afraid to stay home alone?			
E21	Because of your problem, do you feel handicapped?			
E22	Has the problem placed stress on your relationships with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			

Used with permission from GP Jacobson. Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

rev. 05-2019

For Office Use Only
Score P: _____ E: _____ F: _____

16-34 Points (mild)
36-52 Points (moderate)
54+ Points (severe)