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

8200 Bryan Dairy Rd, Suite 340
Largo, FL 33777
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dizzy.com

Dear Patient,

Hello and welcome to our practice!

Our goal is to provide the highest quality of care to all of our patients in a timely and respectful manner. For your first visit, please plan to arrive 15 minutes prior to your appointment.

If any forms accompany this letter, please fill them out and bring them with you to your appointment. Also bring your **Photo ID**, **Insurance Card** and **List of Medications**.

We recommend that you bring a spouse or family member to your initial visit for support.

Please call our office if you have any questions or need to reschedule your appointment.

Thank you for choosing AIB for your health care needs.

Sincerely,

AIB Staff & Providers

The American Institute of Balance®

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

The American Institute of Balance®

Patient Name: _____

Date: _____

Past Medical History

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?_____

Continue to next page

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Patient Name: _____

Date: _____

Please list all of your current medications and supplements

Prescription	Dosage	Frequency	Route	Reason

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

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Patient Name: _____

Date: _____

Audiology Patient Questionnaire

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

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Patient Name: _____

Date: _____

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**_____