Parker
HEARING INSTITUTE

You have been scheduled for a VNG Videonystagmography.

On _____@_____ am/pm

□ **Torrance 4201 Torrance Blvd. Suite 140 Torrance, CA 90503(*Enter through Earl St*)**

□ **San Pedro-1300 W. 6th #1B San Pedro, CA 90723(Dial #0122 at gate)**

The VNG is a test designed to give your physician information about the function of the inner ear balance system. The test requires about 60 minutes. Although most people experience some dizziness during the test, the dizziness is usually of short duration. By the completion of the test, nearly all signs of dizziness should have subsided. However, it is advisable to arrange for someone to transport you to and from the test.

PLEASE CHECK IN 15 MINUTES BEFORE YOUR SCHEDULED TEST. IF YOU ARE NOT CHECKED IN BY YOUR APPOINTMENT TIME, YOU WILL BE RESCHEDULED. OUR APPOINTMENTS RUN ON THE HOUR AND IF YOU ARE LATE, IT WILL DELAY OTHER PATIENTS APPOINTMENTS.

YOU MUST FOLLOW THESE INSTRUCTIONS:

No food or drink 4 hours prior to the exam.
No alcoholic beverages for 48 hours (2 days) before the test.
Please avoid caffeine and nicotine the day of the test.
Discontinue all dizziness medications 48 hours (2 days) prior to the test date. Please avoid sleeping pills, tranquilizers, antihistamines, anti-dizziness medications, anti-depressants and anti-anxiety medications, diuretics, pain medications, sedatives, muscle relaxants, and barbiturates. If you are uncertain, please check with the physician who prescribed the medications before discontinuing them. Please continue blood pressure, heart or diabetic medications.

Please do not wear eye make-up of any kind, foundation, lotion or sun-block on your face. It is best to come with a clean, dry face because make-up will interfere with the VNG test. ***If you have permanent eyeliner, please use or bring your own concealer to cover the area. We cannot perform the test with color around the eye.***

Please call if you have any questions regarding medications or the test in general, ask to speak to an audiologists. Your cooperation in following these instructions is greatly appreciated and will aid your physician in the diagnosis of you problem. If it is necessary to cancel or change your appointment, please call 24 hours in advance. Failure to cancel your appointment may result in a $25 fee charged to you.

(310) 540-4327 Torrance (310)732-1115 San Pedro

Parker
HEARING INSTITUTE

PARKER HEARING INSTITUTE
WILLIAM LEE PARKER, Ph.D. & ASSOCIATES INC
VNG INFORMATION

ACCT#_____

LAST _____ FIRST_____ MI____

DOB_____ AGE_____ SEX □ M □ F MARITAL STATUS □ M □ S □ W □ OTHER

ADDRESS _____

CITY _____ STATE _____ ZIP _____SOCIAL SECURITY #_____

May we contact you via phone/email and have permission to leave message □ Yes □ No

HOME #_____ CELL# _____

EMAIL_____

REFERRING PHYSICIAN _____ PHONE #_____

WHO IS YOUR PRIMARY PHYSICIAN?_____PHONE #_____

HOW DID YOU HEAR ABOUT US: _____

EMPLOYMENT INFORMATION

YOUR EMPLOYER _____ PHONE #_____

OCCUPATION _____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____

CONTACT NUMBER_____

INSURANCE INFORMATION

NAME OF INSURANCE _____ ID #_____

NAME OF INSURED _____ GRP#_____

NAME OF SECOND INSURANCE _____ ID# _____

NAME OF INSURED_____ DOB_____

ASSIGNMENT & RELEASE

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PARKER HEARING INSTITUTE/WILLIAM LEE PARKER PhD & ASSOCIATES INC. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PROFESSIONAL TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. MEDICARE WILL NOT PAY FOR HEARING TESTING FOR THE SELECTION OF HEARING AIDS.

SIGNED _____DATE _____

Name _____ Date _____

WHEN YOU ARE "DIZZY" DO YOU EXPERIENCE ANY OF THE FOLLOWING SENSATIONS? PLEASE READ TH ENTIRE LIST FIRST. THEN CIRCLE YES OR NO TO DESCRIBE YOUR FEELINGS MOST ACCURATELY.

1. Lightheadedness?	YES	NO
2. Swimming sensation in the head?	YES	NO
3. Blacking out?	YES	NO
4. Loss of consciousness?	YES	NO
5. Tendency to fall: To the right?	YES	NO
To the left?	YES	NO
Forward?	YES	NO
Backward?	YES	NO
6. Objects spinning or turning around you?	YES	NO
7. Sensation that you are turning or spinning inside?	YES	NO
8. Loss of balance when walking: Veering to the right?	YES	NO
9. Veering to the left?	YES	NO
10. Headache?	YES	NO
11. Nausea or vomiting?	YES	NO
12. Pressure in the head?	YES	NO

PLEASE CIRCLE YES OR NO OR ANSWER ACCORDINGLY.

1. My dizziness is constant:	YES	NO
in attacks?	YES	NO

2. When did dizziness first occur? _____

3. If in attacks: How often? _____

How long do they last? _____

Do you have any warning that the attack is about to start?	YES	NO
Are you completely free of dizziness between attacks?	YES	NO
4. Does dizziness occur in bed?	YES	NO
5. Do you have trouble walking in the dark?	YES	NO

6. Do you know of any possible cause of your dizziness? What? _____

7. Do you know of anything that will:

Stop your dizziness or make it better? _____

Make your dizziness worse? _____

Precipitate an attack? _____

8. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?	YES	NO
9. Do you have any allergies? _____	YES	NO
10. Did you ever injure your head?	YES	NO
Were you unconscious?	YES	NO
11. Do you take any medications regularly? _____	YES	NO
12. Have you taken any pain pills, sleeping pills, or dizziness medicine in the last 48 hours?	YES	NO
13. Have you had any alcohol in the last 48 hours?	YES	NO

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? CIRCLE YES OR NO AND CIRCLE THE EAR INVOLVED.

1. Difficulty in hearing? YES NO BOTH EARS RIGHT EAR LEFT EAR
   When did this start? _____
   Is it getting worse? YES NO
2. Noise in ears? YES NO BOTH EARS RIGHT EAR LEFT EAR
   Describe the noise. _____
   Does noise change with dizziness? YES NO If so, how? _____
3. Fullness or stuffiness in your ears? YES NO BOTH EARS RIGHT EAR LEFT EAR
   Does this change when you are dizzy? YES NO
4. Pain in your ears? YES NO BOTH EARS RIGHT EAR LEFT EAR
5. Discharge from your ears? YES NO BOTH EARS RIGHT EAR LEFT EAR

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? CIRCLE YES OR NO AND CIRCLE IF CONSTANT OF IF IN EPISODES.

1. Double vision? YES NO CONSTANT IN EPISODES
2. Numbness of face or extremities? YES NO CONSTANT IN EPISODES
3. Blurred vision or blindness? YES NO CONSTANT IN EPISODES
4. Weakness in arms or legs? YES NO CONSTANT IN EPISODES
5. Numbness in arms or legs? YES NO CONSTANT IN EPISODES
6. Confusion or loss of consciousness? YES NO CONSTANT IN EPISODES
7. Difficulty with speech? YES NO CONSTANT IN EPISODES
8. Difficulty with swallowing? YES NO CONSTANT IN EPISODES
9. Tingling around the mouth? YES NO CONSTANT IN EPISODES
10. Lights before your eyes? YES NO CONSTANT IN EPISODES

PLEASE CIRCLE YES OR NO.

1. Do you get dizzy after exertion or overwork? YES NO
2. Did you get new glasses recently? YES NO
3. Do you tend to get upset easily? YES NO
4. Do you get dizzy when you have not eaten for a long time? YES NO
5. Is your dizziness connected with your menstrual period? YES NO
6. Have you ever had a neck injury? YES NO
7. Do you have contact lenses on? YES NO
8. Do you have cataracts? YES NO
9. Do you have a lazy eye (amblyopia) or crossed eyes? YES NO
10. Do you get migraine headaches? YES NO

ADDITIONAL COMMENTS:

_____

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how Parker Hearing Institute, William Lee Parker, PhD and Associates, Inc., .(Herein known as "Parker Hearing Institute") may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or support of the other healthcare operations of the practice. Your PHI is information about you contained in our records which may include your personal health history, symptoms, hearing examination results, Balance test results, hearing aids that you may be wearing, diagnoses, treatment, plans for future treatment, etc. This Notice also describes your rights to access and control your PHI. This Notice is effective as of April 14, 2003.

Uses and Disclosures of Your Protected Health Information

Treatment: Parker Hearing Institute may use your PHI to provide, coordinate, or manage your health care and any related services. For example, your Audiologist may enter your hearing examination results or balance test results into your record and determine the treatment that will work best for you. Your results may then be sent to your physician to ensure that he or she has the necessary information to treat you. We may also share your PHI with the following health professionals if necessary to improve your treatment: consulting physicians, speech therapists, school audiologists or teachers, physical therapists, special educational facilities, etc.

Payment: Parker Hearing Institute may use your PHI to obtain payment for your health care services. For example, we may contact your healthcare provider for authorization to perform services or to obtain payment for services that have been provided. Information about you may be disclosed during this process, but only as necessary.

Healthcare operations: Parker Hearing Institute may use your PHI in order to support the daily operations of the office. For example, we may use your PHI to assess the quality of care during your visit and make changes to improve the quality and effectiveness of the services we provide. We will share some of your PHI with our business associates (such as hearing aid manufacturers, earmold laboratories, warranty companies, etc.) as necessary.

Any other uses and disclosures of your PHI will not be made without your specific authorization, unless required by law. You may revoke this authorization in writing, at any time, if you wish to do so.

Your rights

- You have the right to view and obtain copies of your PHI. However, Federal Law limits your access to certain information including: information obtained under a promise of confidentiality, information related to legal proceedings, psychotherapy notes, etc.
- You have the right to request an amendment to your PHI. You may request an amendment if you feel that the information in your records is incomplete or incorrect. If your request is denied, you have the right to submit a written statement of your disagreement with the decision and it will be included in your records.
- You have the right to obtain an accounting of disclosures of your PHI.
- You have the right to request restrictions on the certain use and disclosure of your PHI. This means that you may ask us not to use or disclose your PHI to certain parties including family members, friends, or other people involved in your care. However, it is not required under Federal Law that our practice agree to a requested restriction.
- You have the right to request confidential communications of your PHI.
- You have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

Our Responsibilities

- We will take every step necessary to maintain the privacy of your PHI.
- We will not use or disclose your PHI in any manner that is not consistent with the terms of this agreement.
- We will notify you if we are unable to agree to a request to restrict the use and disclosure of your PHI.
- We will provide you with this Notice of Privacy Practices explaining our legal duties under the HIPAA Privacy Act and your rights to access and control your PHI.
- We will do our best to accommodate your reasonable requests regarding the privacy of your PHI.
- We are responsible for retaining records of your PHI in accordance with the law and our record retention policy.

Complaints

If you feel that your privacy rights have been violated by our practice, you may file a complaint with our Privacy Officer or with the Secretary of Health and Human Services (HHS). We will not retaliate against you for making a complaint.

For More Information

If you have any questions regarding this Notice of Privacy Practices or if you would like to obtain additional information, please contact our Privacy Officer at (310) 540-4327.

How may we release medical/financial information?

☐Email_____ **☐ Phone**_____

☐Person_____

Your signature below is only acknowledgement that you have been presented with this Notice of Privacy Practices.

We have a cancellation policy fee of $25.00 for notices made 24 hrs or less

Patient Name (Please Print)	Patient/or Guardian Signature	Date