

**ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY**

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Advantra	Healthcare Preferred
Aetna (Diagnostic Only)	Medicare
Blue Cross/Blue Shield of KC & KS (all products)	Humana (all products)
Champus/Tri-Care	Kansas Medicaid
Cigna Healthcare (all products)	Freedom Network
Coventry Healthcare	Health Access
United HealthCare (Diagnostic Only)	

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy lists a required co-payment, I am to pay this at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. **If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc accepts payment by cash, personal check, money order/cashiers checks, Mastercard and Visa. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

Patient/Guardian Signature

Date

ASSOCIATED AUDIOLOGISTS, INC – PATIENT HISTORY

Patient Name: _____ DOB: _____ Date: _____

Primary Concern(s): _____

How or when did your problem first occur? _____

Have any of these concerns been previously evaluated? _____

If so, where/when: _____ Occupation: _____

I. Please check any of the following that you currently have or have had in the past:

- | | |
|---|--|
| <input type="checkbox"/> Family history of hearing loss | <input type="checkbox"/> Head Injury: Date of Injury _____ |
| <input type="checkbox"/> Vision Loss | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bell's Palsy: Affected Side _____ |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Measles and Mumps | <input type="checkbox"/> Stroke/TIA: Affected Side _____ |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Neurological Disorders _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Ear Trauma: Type _____ |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Ear Surgery: Type _____ |
| <input type="checkbox"/> Meniere's disease | <input type="checkbox"/> Tingling/numbness in face |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> MRI or CT-Scan of head: Date _____ Location _____ |
| <input type="checkbox"/> CMV | <input type="checkbox"/> Other _____ |

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- | | | | |
|---|----------|-----------|------|
| <input type="checkbox"/> Difficulty Hearing | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Pain | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Drainage | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Fullness/Pressure | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Noise in your ears/head (tinnitus) | Left Ear | Right Ear | Both |

Describe Sound _____

III. The next section will ask specific questions about hearing loss. If you do not experience hearing loss, please skip this section and proceed to section IV.

- | | |
|---|--|
| <input type="checkbox"/> Difficulty in Quiet Environments | <input type="checkbox"/> Hearing loss began suddenly |
| <input type="checkbox"/> Difficulty in Noisy Environments | <input type="checkbox"/> Hearing loss has progressed gradually |
| <input type="checkbox"/> Trouble understanding television | <input type="checkbox"/> Fluctuations in your hearing |
| <input type="checkbox"/> Trouble understanding on the telephone | |

IV. The next section will ask specific questions about tinnitus (noises in your ears/head). If you do not experience tinnitus, please skip this section and proceed to section V.

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Did your tinnitus begin suddenly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any specific incident precipitate the onset of your tinnitus? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus better? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus worse? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your tinnitus constant? |

- Continued on Back -

V. The next section will ask specific questions about dizziness/vertigo and imbalance. If you do not experience these symptoms, please skip this section and proceed to section VI.

Yes No

- Do you have dizziness/vertigo?
- Does anything provoke your dizziness/vertigo? _____
- Is your dizziness/vertigo constant?
- Are you off balance?
- Have you experienced falls?
- Do you have a fear of falling?
- Do you currently use an assistive device?

VI. Please list all medication you are currently taking, attach an additional page if needed.

Medication: _____ **For:** _____ **Since:** _____

Medication: _____ **For:** _____ **Since:** _____

Medication: _____ **For:** _____ **Since:** _____

Medication: _____ **For:** _____ **Since:** _____

VII. The next section will give you an opportunity to describe what you would like to accomplish through your appointment/time with Associated Audiologists, Inc. Please list your top 3 goals in order of significance (with #1 being most important, #2 being of medium importance, and #3 being less important).

Client Oriented Scale of Improvement (COSI)

Please list your top 3 goals, or things you hope to accomplish, in order of significance.

1 - _____

2 - _____

3 - _____

Hearing Aid Preferences

If results show that hearing aids would be beneficial, are you ready to try amplification?

Please rate your readiness on this 1-10 scale.

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

Please rank these factors in order of importance (1 being most important, 4 being least important):

_____ Hearing in Quiet _____ Hearing in Noise _____ Hearing Aid Expense _____ Cosmetics

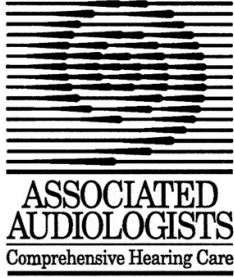
FOR CURRENT HEARING AID USERS ONLY

Do you wear 1 hearing aid or two? _____ How long have you worn hearing aid(s)? _____

Make/Model _____ How old are your present hearing aid(s)? _____

How often do you wear your hearing aid(s)? _____

What would you want to improve about your current hearing aids? _____



Tinnitus Reaction Questionnaire (TRQ)

Name _____

Date Completed: _____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best** reflects how your tinnitus has affected you **over the past week**.

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					

Wilson et al. 1991