



Welcome to Associated Audiologists Inc!

Thank you for contacting our office to schedule an appointment.

Please note the following:

- We kindly ask that if you are ill or experiencing symptoms of illness that you reschedule your appointment.
- Please arrive 15 minutes prior to your scheduled appointment to allow time to collect your paperwork and prepare your chart. Please complete all enclosed case history and entry paperwork (front and back) prior to check-in.
- Bring the completed forms along with your insurance cards, credit/debit card and picture I.D
- Bring a list of your current medications and over the counter supplements, with dosages.
- If your insurance requires a physician's order, please be sure to request it in time for us to receive it for your appointment. It can be faxed to 913-498-1052.
- Please obtain previous hearing, vestibular, and MRI/CT-Scan test results prior to your appointment. Records can be faxed to 913-498-1052.
- Please do not wear make-up to your appointment, as this may interfere with our test interpretation.
- You will be responsible for any co-payments, co-insurance, or deductible amounts applied by your health insurance plan. A claim will be submitted for consideration and you will be notified of any further balance due after the claim has processed. You will be asked for a credit/debit card to place on file for this appointment. See attached information on this policy.
- Most vestibular testing is billable to insurance; however, depending upon your health insurance plan, certain tests and/or services may be non-covered. These fees could range from \$50-250, and will be due at the time of the appointment.

IMPORTANT – PLEASE READ

Your vestibular audiologist has reserved 2 hours for your testing and consultation. Please extend us the courtesy of 24 hours notice if you are unable to keep your appointment. A cancellation fee of \$100 will be billed if timely notification of cancellation is not received.

We look forward to seeing you soon. If you have any questions prior to your appointment, please do not hesitate to contact our office at **913-498-2827**.

Sincerely,
Nicole Sweet
Vestibular Administrative Assistant

Eastern Jackson County
Cliffview Professional Building
816-642-2626

Lawrence
Lawrence Medical Plaza
785-843-8479

Leavenworth
Cushing Medical Plaza
913-682-1870

Manhattan
Manhattan Medical Center
785-539-7361

Northland
Embassy Park Professional Building
816-442-7831

Overland Park
Southridge Medical Building
913-498-2827

Prairie Village
Prairie Village Office Center
913-262-5855

Shawnee Mission
Antioch Hills Medical Building
913-403-0018

ASSOCIATED AUDIOLOGISTS – PATIENT INFORMATION

NOTE: FORMS ARE NOT MOBILE PHONE COMPATIBLE

Please complete and correct any incorrect information to update as needed.

Legal Name _____ Preferred Name _____
Title First MI Last

Date of Birth _____ Gender _____ Preferred Pronouns (optional) _____

Address _____
Street City State Zip

Which is Primary? ☐ Texting is limited to patient care/scheduling related matters. ☐ Check this box if patient is on Hospice Care: ☐
Phone # (Home) _____ ☐ **Permission to email** regarding patient care/
Phone # (Mobile) _____ ☐ DO NOT text: ☐ scheduling? Yes/No ☐
Email Address _____ **Opt out of** quarterly email newsletter and
Associated Audiologists, Inc. will not share your email address with a third party special offers? ☐

REQUIRED: INSURANCE POLICY HOLDER INFORMATION IF OTHER THAN PATIENT (Spouse/Parent/Guardian)

Name _____ Primary Phone # _____
Date of Birth _____

PLEASE COMPLETE IF THE PATIENT IS A MINOR (UNDER 18) OR HAS GUARDIAN/POA

Parent/Guardian Name _____ Parent/Guardian Name _____
Primary Phone # _____ Primary Phone # _____

REFERRAL SOURCE - Please select the most influential source that referred you to our practice.

☐ Physician _____ ☐ Internet ☐ Newspaper/Magazine ☐ Mailing
☐ Family/Friend _____ ☐ Insurance/Health Plan ☐ Other _____

PERMISSION TO RELEASE INFORMATION

COMMUNICATION: I authorize release of information about scheduling, treatment and billing to (spouse, family, etc.):

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL RECORDS: I hereby authorize Associated Audiologists, Inc. to release any and all medical information to the physician(s), person(s), or organization(s) listed below in the course of treatment of the above patient:

Primary Care Physician: _____
Name City Phone Number
Other Physician, Person, or Organization _____

Please click in the box and sign with mouse or touchpad

Signature of Patient or Parent/Guardian

Date

BILLING: IN ORDER TO FILE YOUR INSURANCE CLAIM, THE FOLLOWING MUST BE SIGNED

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Associated Audiologists, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Signature of Patient or Parent/Guardian

Date

ASSOCIATED AUDIOLOGISTS, INC.

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

NOTICE OF RESPONSIBILITY

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

Medicare	Freedom Network
Railroad Medicare	Humana
AARP Medicare Complete	Medica Select
Aetna	Meritain Health/Aetna
Blue Cross/Blue Shield	Tri-Care
Cigna Healthcare	United Healthcare (excluding Community
First Health	Plan & Oxford)

****Associated Audiologists is NOT in network with most Individual Exchange/Marketplace Plans**

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service.

If contracted, 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. If my insurance policy lists a required co-payment, I am responsible for payment of this amount 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/Cashier's Checks, MasterCard, Visa, Discover, American Express, Apple Pay, Care Credit and Wells Fargo Healthcare Finance existing accounts. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Click this link to read full Notice of Privacy Practices:

<https://www.hearingyourbest.com/wp-content/uploads/2025/09/Notice-of-Privacy-Practices-Aug-2025-Final.pdf>

I acknowledge that I received a copy of Associated Audiologists, Inc.'s Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

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

Patient/Guardian Signature

Printed Name

Date



Credit Card Authorization Form

Patient Name: _____ Date of Birth _____ Account # _____

Please initial each statement below to acknowledge that you have read, understand, and agree to the following terms:

- _____ **Payment Responsibility:** Payment for services is an essential part of your healthcare. We require all patients to maintain a valid credit card on file to facilitate payment of co-payments, deductibles, coinsurance, and any balances that are the patient's responsibility after insurance has processed the claim.
- _____ **Insurance Billing:** As a courtesy, Associated Audiologists will submit claims to your insurance carrier when we participate with your plan. You are responsible for any required co-payments, deductibles, coinsurance, and services not covered by your insurance. After your insurance has processed the claim, you will be notified of any remaining patient responsibility in accordance with the payment terms outlined below.
- _____ **Out-of-Network Insurance:** If Associated Audiologists is not contracted with your insurance plan, payment in full is due at the time of service unless other arrangements have been made in advance. If requested, we will provide the necessary documentation for you to submit a claim to your insurance carrier for any available out-of-network benefits.

Credit Card Information	
Card Type:	☐ MasterCard ☐ VISA ☐ Discover ☐ American Express
Cardholder Name (if different from patient): _____	
☐ Check this box if Credit Card Billing Address is the same as Patient's Mailing Address	
Cardholder Billing Address (if different from patient): _____	
Billing Address City, State, Zip (if different from patient): _____	
Last 4 Digits of Card Number: _____	Expiration Date (mm/yy): ____/____

Outstanding Balance: After your insurance provider has processed your claim(s), we will send you a statement showing any remaining balance due. Payment is expected within 30 days of the statement date. If payment is not received, or other payment arrangements have not been made within that timeframe, the outstanding balance will be charged to the credit card on file.

Vestibular (VT) Patients Only: After your insurance provider has processed your claim(s), you will receive a 48-hour notice by email indicating any remaining balance due. If payment is not received, or other payment arrangements have not been made within the 48-hour notice period, the outstanding balance will be charged to the credit card on file.

Authorization: By signing below, I authorize Associated Audiologists to charge the credit card listed above for audiological services, hearing devices, accessories, subscriptions, or any patient responsibility remaining after insurance has processed my claim(s), in accordance with the payment terms outlined above.

Billing Disputes: I understand that charges to my credit card are for services and products provided by Associated Audiologists. If I have a question or believe a billing error has occurred, I agree to contact the clinic promptly so the matter can be reviewed and resolved before initiating a chargeback with my credit card issuer or financial institution.

Privacy and Security: I understand that my payment information will be stored and processed securely. Financial information is used solely for payment processing and is handled in accordance with applicable privacy and security standards. Only the information necessary to process payment is transmitted to the payment processor and financial institution; protected health information is not disclosed as part of the payment transaction except as permitted or required by law.

Signature of Cardholder

Date



Associated Audiologists, Inc. – Pediatric History

Patient Name: _____ DOB: _____ Date: _____

Primary Concern: _____

Does he / she have difficulty hearing/understanding? ☐ No ☐ Both Ears ☐ Right Only ☐ Left Only

When did you first notice difficulty hearing? _____ Onset was ☐ sudden ☐ gradual

Does his/her hearing change (good days/bad days)? ☐ Yes ☐ No

Does he/she have tinnitus (sound in ears)? ☐ No ☐ Both Ears ☐ Right Only ☐ Left Only

How long have they noticed their tinnitus? _____ Onset was ☐ sudden ☐ gradual

Is their tinnitus bothersome? ☐ Yes ☐ No Does it pulse with your heartbeat? ☐ Yes ☐ No

Describe the sound they hear: _____

Does he / she experience dizziness or imbalance? ☐ No ☐ Yes

Describe the dizziness or imbalance: _____

When did these symptoms begin? _____ Does anything trigger these symptoms? _____

Review of Systems and Conditions (please check all current or previous symptoms/conditions):

Ear, Nose and Throat

- ☐ Sound Sensitivity
- ☐ Ear Pain
- ☐ Ear Fullness/Pressure
- ☐ Ear Infections
- ☐ Ear Drainage
- ☐ Ear Drum Perforation
- ☐ Ear Surgery
- ☐ Sinusitis/Seasonal Allergies

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disorder

Eyes

- ☐ Vision Loss
- ☐ Double Vision
- ☐ Blindness

Neurological

- ☐ Peripheral Neuropathy
- ☐ Headaches/Migraines
- ☐ Seizures
- ☐ Head Injury
- ☐ Difficulty Breathing

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Cardiovascular Surgery
- ☐ Fainting / Lightheadedness

Musculoskeletal

- ☐ Decreased Range of Motion
- ☐ Decreased Fine Motor Skills
- ☐ Lack of Coordination
- ☐ Back or Neck Surgery

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ ADD / ADHD
- ☐ Behavior Problems

Infections during Pregnancy

- ☐ Toxoplasmosis
- ☐ Syphilis
- ☐ Rubella
- ☐ Cytomegalovirus (CMV)
- ☐ Herpes

Birth Complications

- ☐ RH Incompatibility
- ☐ Premature
- ☐ Jaundice
- ☐ Low APGAR / Low Oxygen
- ☐ Neonatal Intensive Care (NICU)

Family History

- ☐ Hearing Loss
- ☐ Balance Disorders / Dizziness
- ☐ Headaches / Migraines

Systemic and Other

- ☐ Measles
- ☐ Mumps
- ☐ Tonsillitis
- ☐ Autism
- ☐ Meningitis / Encephalitis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Mononucleosis (Mono)
- ☐ Chicken Pox/Shingles
- ☐ Sickle Cell Anemia
- ☐ Asthma
- ☐ Auto-Immune Disorder

Type:

- ☐ Kidney Disease
- ☐ Cancer

Type:

Treatment:

☐ Genetic Disorders/Syndromes:
Other Medical Conditions: _____

Exposure to loud noise? Ex. Sporting events, headphone use, concerts, hunting, mowing, etc. ☐ Yes ☐ No

If yes, describe: _____

Previous Evaluations and Testing – If yes, please list location and date:

☐ Rehabilitations (OT/PT): _____

Other: _____

Passed Newborn Hearing Screening?

☐ Yes ☐ No ☐ Not sure

Review of Developmental Milestones (please select all that apply)☐ Responds to name 7-9 months☐ Walked by 9-15 months☐ First word 10-12 months☐ Identifies objects 10-12 months

List all current prescription and over-the-counter medications/supplements, or attach current list.

[illegible]



VESTIBULAR PEDIATRIC QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Please answer the questions below to the best of your ability. Some of the questions may not be applicable, but please respond as accurately as possible.

When did the problem first occur? _____
Was it associated with a related event (e.g., change in medication, head injury, or illness) ☐ Yes ☐ No
If yes, please explain: _____
Was the onset of your symptoms: ☐ Sudden ☐ Gradual

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES	NO	
☐	☐	Does he/she experience motion sickness?
☐	☐	Does he/she have a family history of motion sickness?
☐	☐	Do he/she experience migraines?
☐	☐	Do you take any medications regularly? If yes, please attach list.
☐	☐	Has he/she experienced an injury to the head? If yes, when? _____
☐	☐	Has he/she lost consciousness because of an injury to the head?
☐	☐	Has he/she had a neck or back injury?
☐	☐	Are they diabetic? If yes, is it well controlled? ☐ Yes ☐ No
☐	☐	Have you seen other healthcare providers for your current condition?

If yes, check all that apply:

✓	Specialist	✓	Specialist
☐	Cardiologist	☐	Primary Care Physician
☐	Neurologist	☐	Ear, nose, and Throat (ENT)
☐	Emergency Department Doctor	☐	Psychologist/Psychiatrist

II. If he/she does not experience issues with their balance, please skip this section and proceed to section III.

YES	NO	
☐	☐	Are they off balance?
☐	☐	Does he/she have a fear of falling?
☐	☐	Has he/she fallen in the past 12 months?
		If yes, how many times? _____ When was most recent? _____
☐	☐	Does he/she veer to either the right or left when walking?
☐	☐	Does he/she have trouble walking in the dark?
☐	☐	Does he/she have difficulty walking on uneven surfaces (e.g., up/down stairs or lawn)?
☐	☐	Has he/she ever received therapy for your balance?
		If yes, When? _____ Where? _____

(continued) →

III. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES NO

☐	☐	Is the dizziness constant? If you answered yes , please go to section IV.
☐	☐	Does the dizziness occur in attacks (comes and goes)? If yes: Each attack typically lasts: seconds minutes hours days
☐	☐	Do they have any warning that the attack is about to start? If yes, what? _____
☐	☐	Is the dizziness worse at any particular time of the day? If yes, when? _____
☐	☐	Is there anything that will stop the dizziness or make it better? If yes, what? _____
☐	☐	Is there anything that will make the dizziness worse? If yes, check all that apply:

☒	Activity/Situation	☒	Activity/Situation
☐	Quick head/body movements	☐	Menstrual cycle
☐	Loud sounds	☐	Rolling over in bed
☐	Standing up from a lying/sitting down	☐	Bending at the waist
☐	Looking up	☐	Coughing, sneezing, blowing nose, straining
☐	Lying down	☐	Bending over
☐	Large crowds/busy environments	☐	Other: _____

☐	☐	Do you know of any possible cause of the dizziness? If yes, what? _____
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IV. Does he/she currently experience any of the following sensations?

YES NO

☐	☐	Lightheadedness
☐	☐	Swimming sensation in the head
☐	☐	Sensation that you could black out or lose consciousness
☐	☐	Objects are spinning or turning around you
☐	☐	Internal spinning sensation, with objects around you remaining stationary
☐	☐	Rocking/swaying
☐	☐	Foggy headedness

V. Have they ever experienced any of the following sensations? If yes, please *check* the appropriate box and select either “always” or “sometimes.”

YES NO

☐	☐	Double vision	☐ Always	☐ Sometimes
☐	☐	Blurred vision or blindness	☐ Always	☐ Sometimes
☐	☐	Spots before your eyes	☐ Always	☐ Sometimes
☐	☐	Numbness in face, arms, or legs	☐ Always	☐ Sometimes
☐	☐	Weakness in arms or legs	☐ Always	☐ Sometimes
☐	☐	Confusion or loss of consciousness	☐ Always	☐ Sometimes
☐	☐	Nausea or vomiting	☐ Always	☐ Sometimes

Pediatric Dizziness Handicap Inventory

Name: _____ DOB: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that your child may be experiencing because of his/her dizziness or unsteadiness. Please answer "yes" (Y), "no" (N), or "sometimes" (S) to each question.

Answer each question as it applies to your child's dizziness or unsteadiness only.

Item	Question	Y	N	S
1	Because of your child's problem, is it difficult for him/her to walk unassisted?	☐	☐	☐
2	Because of his/her problem, does your child feel tired?	☐	☐	☐
3	Is your child's balance unpredictable?	☐	☐	☐
4	Does your child use a great deal of effort to keep his/her balance?	☐	☐	☐
5	Is your child's life ruled by his/her problem?	☐	☐	☐
6	Does your child's problem make it difficult for his/her to play?	☐	☐	☐
7	Because of his/her problem, does your child feel frustrated?	☐	☐	☐
8	Because of his/her problem, has your child been embarrassed in front of others?	☐	☐	☐
9	Because of his/her problem, is it difficult for your child to concentrate?	☐	☐	☐
10	Because of his/her problem, is your child tense?	☐	☐	☐
11	Do other people seem irritated with your child's problem?	☐	☐	☐
12	Do others find it difficult to understand your child's problem?	☐	☐	☐
13	Because of his/her problem, does your child worry?	☐	☐	☐
14	Because of his/her problem, does your child feel angry?	☐	☐	☐
15	Because of his/her problem, does your child feel "down"?	☐	☐	☐
16	Because of his/her problem, does your child feel unhappy?	☐	☐	☐
17	Because of his/her problem, does your child feel different from other children?	☐	☐	☐
18	Does your child's problem significantly restrict his/her participation in social or education activities, such as going to school, playing with friends, or to parties?	☐	☐	☐
19	Because of your child's problem, is it difficult for him/her to walk around the house in the dark?	☐	☐	☐
20	Because of his/her problem, does your child have difficulty walking up or down stairs?	☐	☐	☐
21	Because of his/her problem, does your child have difficulty walk one or two blocks?	☐	☐	☐
22	Because of his/her problem, does your child have difficulty riding a bike or scooter?	☐	☐	☐
23	Because of his/her problem, does your child have trouble reading or doing schoolwork?	☐	☐	☐
24	Because of his/her problem, does your child have trouble concentrating at school?	☐	☐	☐
25	Does your child's problem make it difficult to do activities that others his/her age can do?	☐	☐	☐
		X4	X0	X2

D.L. McCaslin et al./International Journal of Pediatric Otorhinolaryngology 79 (2015) 1662-1666

Total: _____

Vestibular and Equilibrium

New Patient Instructions and Information

Patient Instructions

Please refrain from excessive alcohol intake **48 hours** prior to your appointment. This may influence or interfere with your test results.

Please inform your audiologist if you have taken the following medications **48 hours** prior to your appointment:

Anti-Vertigo Medications: Antivert, Ru-Vert, Meclizine, etc.

Anti-Nausea Medications: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, scopolamine transdermal.

Please eat lightly prior to your appointment. If your appointment is in the morning, you may have a light breakfast. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

PLEASE DO NOT WEAR MAKEUP (MASCARA, FOUNDATION, ETC.)
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Testing may cause a slight sensation dizziness, which may linger after your evaluation. If possible, we encourage you to have someone accompany you to and from the appointment. If this is not possible, please schedule an additional 15 to 30 minutes after your test, so you may wait for the sensation to clear before leaving our office.



Patient Information

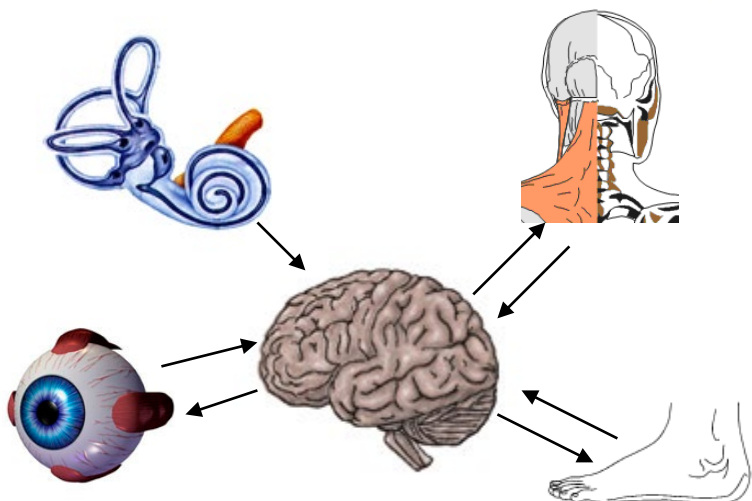
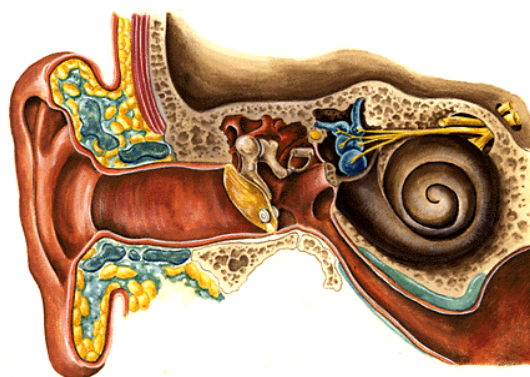
A comprehensive battery of tests will be performed during your evaluation. Prior to each test, a detailed explanation will be given to you, so you gain a better understanding of what we are measuring and what to expect.

Evaluating and Treating Equilibrium Disorders:

Problems with the equilibrium system can result in dizziness, vertigo, and imbalance. The equilibrium system is very complex and cannot be directly observed. To truly understand a patient's equilibrium, a number of sophisticated tests must be performed, correlated, and compared.

-Evaluation-

Balance disorders are often accompanied by changes in hearing and/or ear function. These changes can be acute and hardly noticeable by the patient. Your testing will include comprehensive testing of your outer, middle, and inner ears. These tests include: *audiologic, immittance, and otoacoustic emission* tests.



There are a number of complex pathways that control our equilibrium. Your evaluation will include sophisticated measures of these pathways and your central nervous system. These tests are: *Vestibular Evoked Myogenic Potential, Auditory Brainstem Response, Rotary Chair, Dynamic Visual Acuity, Electro-oculography, Sensory Organization Performance, Vestibular Head Impulse Testing, and Video/Electro-nystagmography*

-Treatment-

There are several well-researched, successful, and widely used treatments and management strategies for problems of the equilibrium system. These treatments address issues such as vertigo, dizziness, lightheadedness, and balance problems. All forms of treatment should be preceded by a comprehensive evaluation and diagnosis. This ensures that the specific treatment chosen is appropriate for the given diagnosis.





CREDIT CARD ON FILE FAQs

Why do I need to leave a credit card on file? While most of our patients pay their balances in a timely manner, this is not always the case. Neglected balances for services already rendered affect the cost of health care for everyone. This system will streamline billing processes and help keep costs low.

How does having a credit card on file work? At the time of check-in, your credit card will be electronically stored in encrypted form. After your claim has settled, we will email you a notice indicating your total balance due. Payment is expected in our office within 48 hours of the notification. If payment is not received, your card will be charged for any remaining balance that is your responsibility.

Is my credit card information secure? Yes. Credit card numbers are encrypted and stored by Heartland Merchant Processing. No credit card numbers are stored in our practice.

What charges will my card be used for? Your card will only be charged for your patient responsibility once your insurance claim has been settled.

What if my card is declined or expired? If we attempt to use your card and it is declined or has expired, we will contact you for updated information. We reserve the right to charge a \$25 administrative fee for any cards that are declined.

What is a deductible and how does it affect me? A deductible is the total dollar amount you must pay during the year for medical expenses before your insurance coverage begins to pay. For example, if your insurance plan has a \$500 deductible, you will pay the first \$500 of any medical expenses incurred during that year before insurance begins to pay.

What if I don't have a credit card? You may leave a Health Savings Account (H.S.A.) or Flexible Spending card on file with us. You may pay your charges, in full, with cash or check at the time of service. Or, you may speak with us regarding making monthly payments.

How will I know when my deductible has been met? Call your insurance company before your visit to determine how much of your deductible has been met for the year. Or, you may also be able to view your insurance information via the insurance company's website.

What if I have a dispute with my bill? Please contact us immediately at 913-384-2105 so we can promptly address your concerns.