

## Tinnitus Case History

### DEMOGRAPHICS

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Referring/Primary Care Physician(s): \_\_\_\_\_

Marital Status:     Single     Married     Widowed     Divorced     Other  
                                   Mr.             Mrs.             Ms.             Miss             Dr.

What is your primary reason for coming in today? \_\_\_\_\_

Who can we thank for sending you to our office today? \_\_\_\_\_

### HEARING HISTORY

Have you ever had a hearing evaluation before?     Yes                     No

If you suspect a hearing loss, do you feel the onset was:     Gradual     Sudden     Fluctuating

Have you been around loud sounds regularly?     Yes                     No

Do you have trouble hearing any of the following?

Doorbell             Telephone Ring             Alarm Clock             Smoke Alarm

Have you ever worn a hearing aid?     Yes                     No

Do you use a hearing aid now?     Yes                     No

### MEDICAL HISTORY

Have you had earaches or drainage from your ears in the past 90 days?     Yes                     No

Have you ever had medical/surgical treatment for your ears?     Yes                     No

Do you ever experience balance issues, dizziness, lightheadedness, or falls?     Yes                     No

Have you ever had a head injury?     Yes                     No

Do you experience tinnitus regularly? (i.e. ringing, buzzing, humming, roaring)     Yes                     No

Does anyone in your immediate, biological family have hearing loss?     Yes                     No

Are you taking blood thinners?     Yes                     No

Have you been diagnosed with any of the following?

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Cancer	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> High Fevers	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Concussion/Skull Fracture	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dementia or Alzheimer's	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Depression and/or <input type="checkbox"/> Anxiety	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Vision Issues

Other, please explain \_\_\_\_\_

Are you allergic to latex, acrylic, silicone, etc?     Yes (which?) \_\_\_\_\_     No

Is there any other important information related to your hearing that the doctor should know?

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What do you consider is your main problem?     Hearing     Tinnitus     Sound tolerance

## TINNITUS

*Tinnitus refers to any kind of sound in your head...ringing, hissing and so on. Think only about your tinnitus in regard to the following questions.....*

What does the tinnitus sound like to you? \_\_\_\_\_  Constant  Intermittent

In which ear is your tinnitus?  Right  Left  Both  Head  Other

How long ago did you notice the tinnitus?  Past year  1-3 years  3-10 years  10+ years

Do you remember the onset of your tinnitus? \_\_\_ Yes \_\_\_ No

Was it a sudden or progressive onset?  Sudden  Progressive

Was it related to any other medical or environmental condition? \_\_\_ Yes \_\_\_ No

\*Does your tinnitus pulse with your heartbeat? \_\_\_ Yes \_\_\_ No

\*Is your tinnitus triggered by head or neck movement? \_\_\_ Yes \_\_\_ No

Is there any one in your family who has/had tinnitus? \_\_\_ Yes \_\_\_ No

Have you consulted any professional or tried any treatment for your tinnitus? \_\_\_ Yes \_\_\_ No

If yes, explain \_\_\_\_\_

Does anything make your tinnitus change? \_\_\_\_\_

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## SOUND TOLERANCE

*Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions.....*

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? \_\_\_ Yes \_\_\_ No

Do you have a decreased tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? \_\_\_ Yes \_\_\_ No

### ***Does sound in your environment....***

Cause an increase in your tinnitus?                      always                      sometimes                      never

Cause you to avoid going certain places?                      always                      sometimes                      never

Cause you to feel irritated?                      always                      sometimes                      never

**Assignment of Insurance Benefits/Release of Information**

\_\_\_\_ Insurance coverage is an agreement between you and your insurance carrier. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Elevate Audiology. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance, based on my individual insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment.

**Permission for Treatment**

\_\_\_\_ I hereby voluntarily consent to audiological care and audiological diagnostics by Elevate Audiology, deemed advisable and necessary in the diagnosis and treatment of my hearing condition. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

**Receipt of Notice of Privacy Policy**

\_\_\_\_ I have received a copy of Elevate Audiology's Privacy Policies and understand its contents. I further acknowledge that a copy of the current notice will be posted in the reception area, website, and any changes will be made available to me.

*Please check all boxes then sign below*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Disclosure of Patient Authorization Record**

I authorize that my personal information, hearing healthcare treatment, and financial information may be assessed by and disclosed to the individuals listed (i.e. spouse, family member, caregiver, friend, etc.).

Name	Relation	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Confidential Communication**

I authorize communications by Elevate Audiology concerning scheduled appointments, treatment, practice information, newsletters, etc. through the following methods:

Please select all that apply:       Phone       Text       Email       Work

Home:	(____) _____ - _____	Authorize messages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell:	(____) _____ - _____	Authorize messages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work:	(____) _____ - _____	Authorize messages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Email: \_\_\_\_\_

Preferred method for appointment reminders?       Phone       Text       Email       Work

**Elevate Audiology  
Office & Financial Policy**

**Welcome to our office**

Please read this policy carefully and feel free to ask questions regarding any part of the form. Our goal is to provide you excellent hearing care in a comfortable, personal, and cost-effective manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

**Payment at the time of service is expected.**

Payment for services is due in full at the time of service. Payments to Elevate Audiology may be made by cash, check, Visa, MasterCard, or approved financing companies.

In order to bill your insurance company for your hearing care, it is extremely important that we obtain complete and accurate information about your primary and supplement insurance coverage, including phone numbers, addresses, and a copy of your cards. Even though we bill your insurance company for you, we will still collect any office copayments from you at the time of service.

**Verification of Benefits**

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what audiology coverage is available within your policy. This can only be done on the day of your appointment if time permits. **You as the policy holder are primarily responsible to verify benefits.** We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

**Referrals**

If your insurance company requires a referral and/or preauthorization/precertification **you are** responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service. (This will be our discretion if time permits). An option at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary care doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

**Medicare**

We accept assignment from Medicare so all payment from Medicare will be made directly to the doctor. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves, not just the 20% they do not pay.

**No Show and Cancellation Appointments/Late Arrivals**

We will reach out to you at least the day before your appointment to confirm your attendance. If we do not reach you, we will leave a message via voicemail or email (if able). Please give at least 24 hours notice if unable to keep an appointment. We reserve the right to charge a \$25 fee for missed appointments or appointment cancelled without 24 hour notice. We understand late arrivals happen. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows, otherwise, we will need to reschedule.

**Returned Checks**

There is a fee (currently \$25) for any checks returned by the bank.

**Monthly Statement**

If you have a balance on your account we will send you a monthly statement. It will show the balance and any new charges to the account. Any unpaid balances older than 30 days may be subject to 1.5% interest fee per month.

**Payments**

Unless other arrangements are approved by us in writing, the balance on your account is due and paid when the statement is issue. If not paid by the end of the month it will be considered past due.

**Past Due Accounts**

If your account becomes past due, we will take the necessary steps to collect this debt. This may mean a collections agency. In the event of legal action, you will be responsible for payment of any additional charges equal to the cost of collections, including agency fees, attorney fees, and court costs incurred, as permitted by law governing this transaction.

**Effective Date**

Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

**Financial Agreement**

- I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
- I have read the policies above and understand them.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I authorize Elevate Audiology to release to my insurance carrier any medical information needed to obtain payment for services.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

**We will work with you to ensure your hearing care is the finest available and it does not become a financial burden.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_