ELEVATE AUDIOLOGY
Hearing & Tinnitus Center

TINNITUS CASE HISTORY

DEMOGRAPHICS

Name: ______________________ Today's Date: ______________________

Birthdate: ______________________ Age: ______________________

Referring/Primary Care Physician(s): ______________________

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

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 exposed to very loud sounds? ☐ Yes ☐ No

If yes, ☐ Military ☐ Recreational ☐ Employment ☐ Music

Have you ever worn a hearing aid? ☐ Yes ☐ No

Do you use a hearing aid now? ☐ Yes ☐ No

Check if you have trouble hearing any of the following: ☐ Doorbell ☐ Telephone Ring ☐ Alarm Clock ☐ Smoke Alarm

MEDICAL HISTORY

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

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

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

Have you ever had a significant head injury? ☐ Yes ☐ No

Do you have a known genetic family history of hearing loss or ear problems? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

Do you smoke anything, or are you exposed to secondhand smoke? ☐ Smoker ☐ No ☐ Secondhand

Do you or your family have concerns about your memory or brain health? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

☐ Anxiety	☐ Autoimmune Disorder	☐ Bell's Palsy	Blood Pressure ☐ High ☐ Low	☐ Cancer ☐ Chemo ☐ Radiation	☐ Chronic Kidney Disease	☐ Concussion/ Skull Fracture	☐ Dementia or Alzheimer's
☐ Depression	Diabetes ☐ Type I ☐ Type II	☐ Heart Disease	☐ Hepatitis	☐ High Fevers	☐ HIV/AIDS	☐ Latex, Acrylic or Silicone Allergy	☐ Measles
☐ Meningitis	☐ Mild Cognitive Impairment	☐ Multiple Sclerosis	☐ Mumps	☐ Neurological Disorders	☐ Pacemaker	☐ Parkinson's	☐ Scarlet Fever
☐ Seizures	☐ Sinus or Allergy Issues	☐ Stroke/TIA	☐ Thyroid Issues	☐ Tuberculosis	☐ Vision Issues		
☐ Other, please explain: ______________________							

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 ☐ 4-10 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 anyone 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? ______________________________
____

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

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TINNITUS FUNCTIONAL INDEX (TFI)

Patient Name ______________________________ Date ______/______/______
First Last MI mm dd yyyy

Instructions: Please read each question below carefully. To answer a question, select ONE of the numbers that are listed for that question, and CHECK the box.

I	Over the Past Week...
	1. What percentage of your time awake were you CONSCIOUSLY aware of your tinnitus? Never aware ▶ ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ◀ Always aware
	2. How STRONG or LOUD was your tinnitus? Not at all strong or loud ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Extremely strong or loud
	3. What percentage of your time awake were you ANNOYED by your tinnitus? None of the time ▶ ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100% ◀ All of the time

SC	Over the Past Week...
	4. Did you feel IN CONTROL in regard to your tinnitus? Very much in control ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Never in control
	5. How easy was it for you to COPE with your tinnitus? Very easy to cope ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Impossible to cope
	6. How easy was it for you to IGNORE your tinnitus? Very easy to ignore ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Impossible to ignore

C	Over the PAST WEEK, how much did your tinnitus interfere with...
	7. Your ability to CONCENTRATE? Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered
	8. Your ability to THINK CLEARLY? Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered
	9. Your ability to FOCUS ATTENTION on other things besides your tinnitus? Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

SL	Over the Past Week...
	10. How often did your tinnitus make it difficult to FALL ASLEEP or STAY ASLEEP? Never had difficulty ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Always had difficulty
	11. How often did your tinnitus cause you difficulty in getting AS MUCH SLEEP as you needed? Never had difficulty ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Always had difficulty
	12. How much of the time did your tinnitus keep you from SLEEPING as DEEPLY or as PEACEFULLY as you would have liked? None of the time ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ All of the time

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A	Over the PAST WEEK, how much has your tinnitus interfered with…

13. Your ability to HEAR CLEARLY?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

14. Your ability to UNDERSTAND PEOPLE who are talking?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

15. Your ability to FOLLOW CONVERSATIONS in a group or at meetings?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

R	Over the PAST WEEK, how much has your tinnitus interfered with…

16. Your QUIET RESTING ACTIVITIES?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

17. Your ability to RELAX?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

18. Your ability to enjoy “PEACE AND QUIET”?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

Q	Over the PAST WEEK, how much has your tinnitus interfered with…

19. Your enjoyment of SOCIAL ACTIVITIES?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

20. Your ENJOYMENT OF LIFE?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

21. Your RELATIONSHIPS with family and friends?

Did not interfere ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Completely interfered

22. How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS, such as home maintenance, school work, or caring for children or others?

Never had difficulty ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Always had difficulty

E	Over the Past Week…

23. How ANXIOUS or WORRIED has your tinnitus made you feel?

Not at all anxious or worried ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Extremely anxious or worried

24. How BOTHERED or UPSET have you been because of your tinnitus?

Not at all bothered or upset ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Extremely bothered or upset

25. How DEPRESSED were you because of your tinnitus?

Not at all depressed ▶ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ◀ Extremely depressed

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: ______________________________ Date of Visit: ______________________________

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed or hopeless:	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself—or that you're a failure or have let yourself or your family down:	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television:	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite—being so fidgety or restless that you have been moving around a lot more than usual:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3

Column Totals: __________ + __________ + __________

All Totaled: __________

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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REVISED HEARING HANDICAP INVENTORY - SCREENING (RHHI-S)

Instructions:
Please check “yes,” “no,” or “sometimes” in response to 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	SOMETIMES	NO
S	Does a hearing problem cause you difficulty when listening to the TV or radio?	☐	☐	☐
S	Does a hearing problem cause you difficulty when attending a party?	☐	☐	☐
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
E	Does a hearing problem cause you to feel left out when you are with a group of people?	☐	☐	☐
S	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
E	Do you feel handicapped by a hearing problem?	☐	☐	☐
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
E	Does a hearing problem cause you to feel uncomfortable when talking to friends?	☐	☐	☐
S	Does a hearing problem cause you to avoid groups of people?	☐	☐	☐
S	Does a hearing problem cause you to visit friends, relatives or neighbors less often than you would like?	☐	☐	☐

How important is it for you to hear better? Choose a box on the line.

Not Very Important ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Very Important
0 1 2 3 4 5 6 7 8 9 10

How motivated are you to wear and use hearing aids if recommended? Choose a box on the line.

Will Not Wear ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Will Wear Consistently
0 1 2 3 4 5 6 7 8 9 10

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CURRENT MEDICATIONS LIST

Name: ____

Date Last Updated: ____________________ ________________________ ______________________ _______________________

Prescription Medications:

Name of Medication	Dosage	Frequency (i.e., once per day)	Condition Medication Taken For	Physician Who Prescribed Med

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 insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment. Any required physician orders are the responsibility of the patient to receive prior to the appointment time.

Permission for Treatment

______ I hereby voluntarily consent to audiological diagnostics, care and services by Elevate Audiology, deemed advisable and necessary in the diagnosis and treatment of my audiology condition. I acknowledge that no cures nor guarantees have been made to me as a result of treatment or examination in the office.

Receipt of Notice of Privacy Policy

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

Education and Marketing

______ I authorize Elevate Audiology to send me educational and marketing information on the products and services offered by Elevate Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Please check all boxes, then sign below.

____ ____________________

Signature Date

Disclosure of Patient Authorization Record

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

Name	Relation	Telephone #
____________	____________	____________
____________	____________	____________
____________	____________	____________

Confidential Communication

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

Please select all that apply: ☐ Phone ☐ Text ☐ Email ☐ Work

Home: (__________) __________-__________ Authorize messages? ☐ Yes ☐ No

Cell: (__________) __________-__________ Authorize messages? ☐ Yes ☐ No

Work: (__________) __________-__________ Authorize messages? ☐ Yes ☐ 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 important that we obtain complete and accurate information about your primary and supplemental insurance coverage, including phone numbers, addresses and a copy of your cards. We will submit a claim to your insurance as a courtesy to you. If your insurance reimburses us rather than you, we will refund you or apply the amount to your next visit. Out-of-network insurance beneficiaries and noncovered services are the financial responsibility of the patient.

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify audiology coverage within your policy. Verification is not a guarantee of payment, and you as the policyholder are primarily responsible for verifying benefits. This can only be done on the day of your appointment if time permits. You are responsible for any coinsurance, deductibles or fees for noncovered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

Referrals

If your insurance company requires a referral 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. An option will be to reschedule the appointment or 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.

Medicare

We accept assignments from Medicare, so all payments from Medicare will be made directly to our office for Medicare-covered services only. 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 one 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 appointments canceled without 24 hours' 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 after your scheduled time. We will need to reschedule if we are unable to accommodate due to late arrival.

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 a 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 issued. 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 collection 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 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.

______________________________________ ____________________

Signature Date