Patient Demographic Form

Name:_______________________________________ Todays Date:______/______/_______

Date Of Birth:__________________ Age:_______ Sex: M / F Right/Left Handed: R / L

Address:____________________________ City:_____________ State:_____ Zip:_________

Telephone #:_____________________________ Email:_______________________________

Insurance Company #1:_____________________Insurance Co.#2:____________________

Emergency Contact Name:____

Relationship to Patient:______________________ Phone #:_________________________

Primary Care Doctors Name:_________________________ City:______________________

How did you hear about us?:____

Print Name:____

Signature:____

BALANCE & DIZZINESS CENTER

17 Brinkerhoff Terrace Suite 201, Palisades Park NJ 07650
201 947-4777

Dizziness, Balance & Falls Questionnaire

Patient's Name: ___________________________ Date: ______________

Patient's Date of Birth (Mon/Day/Yr): ______/______/______

1.) Circle what best applies

[A] Dizziness [B] Balance [C] Both

Section A

Dizziness questions: (If you are NOT DIZZY SKIP this section) Mark all that apply:

2.) Duration of dizziness episodes:

[ ] Seconds
[ ] Minutes
[ ] Hours

3.) When did symptoms first begin?

[ ] Days ago
[ ] Weeks ago
[ ] Months ago
[ ] Years ago

4.) My dizziness is…

[ ] Constant
[ ] Periodical

5.) These positions make me dizzy

[ ] Sitting
[ ] Lying in bed
[ ] Standing
[ ] Getting up
[ ] Turning
[ ] Bending

6.) My dizziness is best described as…

[ ] I feel like I am spinning/moving
[ ] I see the world around me spinning/moving
[ ] Lightheadedness/ "swimming" sensation

7.) My last dizziness episode was…

[ ] Today
[ ] Days ago
[ ] Weeks ago
[ ] Months ago

8.) Symptoms present with…

[ ] Nausea
[ ] Vomiting

MEDICAL HISTORY – Mark all that apply:

[ ] Headaches
[ ] Migraines
[ ] Motion Sensitivity
[ ] Sensitivity to light
[ ] Sensitivity to sound
[ ] Sensitivity to smell
[ ] Facial Numbness
[ ] Double Vision
[ ] Blurred Vision
[ ] Cataracts
[ ] Macular degeneration
[ ] Glaucoma
[ ] Visual floaters/ spots
[ ] Snoring/Sleep Apnea
[ ] Shingles outbreaks
[ ] Cold sores / fever blisters
[ ] Loss of consciousness
[ ] Falls
[ ] Serious Head injury
[ ] Heart Attack
[ ] Stroke
[ ] High blood pressure
[ ] Low blood pressure
[ ] Orthostatic hypertension
[ ] COPD
[ ] Diabetes
[ ] Thyroid problems
[ ] Kidney problems
[ ] Liver problems
[ ] Stress
[ ] Anxiety
[ ] Panic attacks
[ ] Depression
[ ] Seizures
[ ] Chemotherapy
[ ] Staggered gait
[ ] Tinnitus
[ ] Hearing loss

Please list any major surgeries you had,

____

____

____

Please list any medications you are taking,

____

____

____

Please list any medication allergies you have,

____

____

____

Prior relevant medical evaluations, diagnostic testing, and treatment:

i. Have you seen other healthcare providers for you current condition? [ ] yes [ ] no

If **yes**, who?:

[ ] Primary care doctor

[ ] ENT/HNS doctor

[ ] Neurologist

[ ] Cardiologist

[ ] Emergency room doctor

[ ] other : __________________

Additional Information

Is there anything else you would like to make sure to tell your physician about?

____

____

____

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Notice of Privacy Practices Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your *Notice of Privacy Practices Consent Form* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices Consent Form.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

INSURANCE AUTHORIZATION, FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims, provided verification of your insurance policy(s) allows assigned benefits and coverage for the services rendered.

I hereby authorize payment directly from my insurance carrier to the rehabilitation agency for the benefits due to me in my pending claim. I further authorize the release of any medical information required by my insurance carrier.

I, the undersigned, understand that the rehabilitation agency will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make complete payment for services rendered, I am responsible for complete payment of physical therapy services, including any and all deductibles, coinsurance amounts. I am responsible for payments that are denied for lack of medical necessity as determined by your health insurance payer. The charges incurred are not subject to any fee schedule or reductions unless the rehabilitation agency is a contracted managed care provider for my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand the payments of the fee are not contingent upon a settlement of litigations; however, I hereby instruct my attorney to pay the rehab agency in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting the assignment means that the provider of services agrees to accept the “allowable” charges as determined by Medicare as full payment. However, you much remember Medicare generally pays 80% of the allowable charges. Therefore, you are still responsible for the 20% balance. In addition to the 20% you are responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

A rehab agency representative has explained to me that under the Medicare guidelines, I will be responsible for 20% of the allowable charge. The rehab agency has agreed to accept assignment of the benefits on this portion of the charges; I also understand that should the supplemental insurance company fail to pay for these charges with a “reasonable length of time”, or send payment directly to me, I will become responsible for payment in full.

The above Patient Financial Policy and Agreement has been read and/or explained to me:

Patient’s Signature:____

Date:____