TPA Tinnitus Practitioners Association

Tinnitus Questionnaire

ELEVATE AUDIOLOGY Hearing & Tinnitus Center

Patient Name: _____ **Date:** _____

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

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

_____

Ear Health History

Have you been exposed to loud sounds/noise? ☐Yes ☐No If yes, explain_____

Have you ever had ear surgery? ☐Yes ☐No If yes, ear? ☐Right ☐Left type?_____

Have you ever had any head/ear trauma? ☐Yes ☐No If yes, explain_____

Have you ever taken medication that had a toxic effect on your hearing? ☐Yes ☐No If yes, type?_____

Does anyone in you immediate, biological family have a hearing loss? ☐Yes ☐No

*Have you experienced any drainage from your ear(s) within the last 90 days? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

*Do you suffer from pain or discomfort in your ear(s)? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have temporomandibular joint (TMJ) disorder? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have a congenital or traumatic deformity of the ear? ☐Yes ☐No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

☐Right ☐Left ☐Both ☐Neither

*Do you suffer from acute or chronic dizziness? ☐Yes ☐No

Please list all major surgeries (Past 10 years):

_____

_____

_____

Please list any serious illnesses (Past 10 years):

_____

_____

_____

Are you diabetic? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

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? ☐Recently ☐1-3 years ☐3-10 years ☐More than 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 other professional or tried any treatment for your tinnitus? ☐Yes ☐No

If yes, explain_____

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

Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions…

When was your last hearing exam? _____ By whom? _____

What were the results? _____Recommendations?_____

Have you ever worn hearing aids? ☐Yes ☐No

*Have you experienced a sudden hearing loss? ☐Yes ☐No When? _____

Does your hearing….

Limit or hamper your personal or social life?	always	sometimes	never
Cause you to hear people but not understand what they are saying?	always	sometimes	never

Have you experienced any stressful events within the last 12 months? ☐Yes ☐No

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?	___ 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 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: _____