## Welcome to Otolaryngology Associates of Tennessee Balance Program

Patients with chronic dizziness and balance problems often find it very difficult to carry on with normal, everyday activities. We hope your visit to us serves as the final destination in your journey to restoring your balance wellness. By completing this paperwork, we are better able to address and diagnose your vestibular (balance) concerns and ensure you are only scheduled for the most appropriate tests.

Please review and complete the following packet of information. **You will ONLY be scheduled for a balance assessment once we have received and reviewed all of this completed packet.** You may complete this packet in our waiting room at the end of your ENT appointment and return it to our receptionist or you may complete it at home and return it to any of our offices in person, via mail, or fax.

- Mail - send via mail to OAT Balance Program Attn: Dr. Nicole Payne, 410 42nd Ave North, Suite 200, Nashville, TN 37209-2331
- Fax - (615) 327-4449 Attn: Dr. Nicole Payne

## What to Expect

**Before Your Visit**
Our staff will schedule your initial office appointment as well as any return visits. If you have questions about your upcoming or recent visit, or need assistance with new-patient paperwork, please contact us. Please allow two hours for test completion. Please do your best to arrive at your scheduled appointment on time, so we are able to provide you and your referring physician with the most comprehensive test results. Your time is as valuable as ours; and therefore, we make every attempt to spend the same amount of time on each test completed with every patient.

**At Arrival**
After check-in, we'll ensure your comfort as quickly as possible and that necessary forms are completed.

**Consultation, Exam and Testing**
Prior to your examination, your audiologist will sit down and discuss the reason for your visit and review any symptoms. Your audiologist will also review what to expect during the exam and testing. All testing is non-invasive and essential to the assessment and overall evaluation of your ear health. Once your testing is complete, each component of testing is carefully analyzed and reviewed. This process to determine balance function is as important as each test conducted and will be explained to you. A detailed summary report will also be sent to your referring physician, if applicable, regarding our conclusions and recommendations.

# Patient Instructions for Vestibular Function Testing

In most circumstances, these tests take approximately 2 hours to administer.

**PLEASE CHECK IN 15 MINUTES BEFORE YOUR SCHEDULED TEST. IF YOU ARE NOT CHECKED IN BY YOUR APPOINTMENT TIME, YOU WILL BE RESCHEDULED. OUR APPOINTMENTS RUN ON THE HOUR AND IF YOU ARE LATE, IT WILL DELAY OTHER PATIENTS APPOINTMENTS.**

**So that we can obtain accurate results for you and your physician, we ask that you review the following instructions carefully:**

- Fill out this packet and return to our office prior to your appointment via mail or fax.
- If you are already unsteady or dizzy before your appointment, we suggest that you bring someone with you who can drive you home after the testing has been completed.
- We ask that you do not eat a heavy meal prior to the appointment.
    - Please avoid alcoholic beverages for 48 hours (2 days) before the test.
- Certain medications may influence the body's response to the testing, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment: Anti-dizziness medication, anti-nausea medication, allergy or cold medications that make you sleepy.
- CONTINUE all of your life sustaining medications such as water pills, blood thinners, medications for seizures, heart conditions, blood pressure, diabetes, lung or breathing conditions, asthma, kidney or liver problems, etc. You may also continue antibiotics or steroids.
- Please DO NOT wear makeup, especially mascara and eye liner, on your face/neck. It is best to come with a clean, dry face/neck because makeup will interfere with the results of the testing.
- Casual, comfortable clothing is recommended, and patients are advised to wear slacks as testing includes sitting and lying down.
- If you have hearing devices or cochlear implants, please wear them to your appointment.

If you have any questions regarding this information or about your appointment, please call our office at (615) 340-4000.

ID #: _____

OTOLARYNGOLOGY
Associates of Tennessee

# Dizziness and Balance Case History

Name: _____ DOB: _____ Today's Date: _____

1. Please describe your symptoms:

   _____

   _____

   _____

2. Do your symptoms include any of the following? Please circle all that apply:
   a. Lightheadedness
   b. Tendency to lose balance or to fall
   c. Objects spinning or turning around you
   d. Sensation that you are spinning or turning
   e. Headache
   f. Nausea or vomiting
   g. Pressure in head
   h. Loss of consciousness

3. When did your symptoms first occur? _____

4. Are your symptoms constant or do they occur in attacks/episodes? _____
   How often do episodes occur? _____ How long do they last? _____

5. Are your symptoms affected by any of the following? Please circle all that apply:
   a. Head movement
   b. Body movement
   c. Standing up
   d. Walking in a dark room
   e. Walking on uneven surfaces
   f. Loud noises
   g. Coughing, sneezing, straining
   h. Movement of objects in environment

6. Do you know anything that will stop your symptoms or make them better? _____
   Make them worse? _____ Bring on an episode? _____

7. Do you experience any of the following hearing symptoms? Please circle all that apply:
   a. Hearing loss
   b. Hearing fluctuations
   c. Ringing/buzzing/roaring
   d. Ear fullness or pressure

8. Please circle any of the following that apply to your medical/health history:
   a. Head injury
   b. Neck or back problems
   c. Migraines or headaches
   d. Ear surgery
   e. Eardrum perforations
   f. High blood pressure
   g. Stroke
   h. Diabetes
   i. Tobacco Use
   j. Alcohol Use
   k. Depression
   l. Anxiety

9. Do you wear glasses or contacts? _____ Any history of eye disease? _____

10. Is there any other information that you would like to provide about your symptoms?

    _____

    _____

    _____

# Assessment (Office Use Only)

**DHI Score**:_____ Mild 16-34 Mod 36-52 Sev 54+

**DSP Category** (greater than 60%): Unsteadiness, PPPD, BPPV, Neuritis, SCD, Meniere's, Migraine

**Ocular Motor:**

| | | | | |
|---|---|---|---|---|
| Smooth Pursuit: | Gain? Y N | Symmetry? Y N | | Eye characteristics_____ R L B |
| Saccades: | Latency? Y N | Velocity? Y N | Accuracy? Y N | Eye characteristics_____ R L B |
| OPK: | Gain? Y N | Symmetry? Y N | | Eye characteristics_____ R L B |

**Gaze:**

Center _____ Right _____ Left _____

Up _____ Down _____

(Key: Nystagmus present: Y N; Direction: Right (R), Left (L), Up (U), Down (D), Direction-Changing (DC); Vision (V), Vision Denied (VD))

**Positional:**

Sitting _____ Supine _____ Head Right _____

Head Left _____ Right Lateral_____ Left Lateral_____

Pre-Caloric_____

(Key: Nystagmus present: Y N; Direction: Right (R), Left (L), Up (U), Down (D), Direction-Changing (DC); Vision (V), Vision Denied (VD))

**Dix-Hallpike:**

| | | | |
|---|---|---|---|
| Head hanging left: | Vertigo? Y N | Nystagmus? Y N | Nystagmus characteristics: Direction R L B Duration _____s |
| Head hanging right: | Vertigo? Y N | Nystagmus? Y N | Nystagmus characteristics: Direction R L B Duration _____s |

**Roll Test:**

| | | | |
|---|---|---|---|
| Head left: | Vertigo? Y N | Nystagmus? Y N | Nystagmus characteristics: Direction R L B Duration _____s |
| Head right: | Vertigo? Y N | Nystagmus? Y N | Nystagmus characteristics: Direction R L B Duration _____s |

**Caloric:**

Gain (d/s): RW _____ LW _____ LC _____ RC _____ Total _____

Unilateral Weakness: _____ % R L Directional Preponderance: _____ % R L

Monothermal UW: _____ % R L

# Dizziness Handicap Inventory

**Instructions**: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness or balance problem. Please answer every question. Please do not skip any questions.

| Item | Yes | Sometimes | No |
|---|---|---|---|
| 1. Does looking up increase your problem? | ☐ | ☐ | ☐ |
| 2. Because of your problem, do you feel frustrated? | ☐ | ☐ | ☐ |
| 3. Because of your problem, do you restrict your travel for business or recreation? | ☐ | ☐ | ☐ |
| 4. Does walking down the aisle of a supermarket increase your problem? | ☐ | ☐ | ☐ |
| 5. Because of your problem, do you have difficulty getting into or out of bed? | ☐ | ☐ | ☐ |
| 6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties? | ☐ | ☐ | ☐ |
| 7. Because of your problem, do you have difficulty reading? | ☐ | ☐ | ☐ |
| 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away, increase your problem? | ☐ | ☐ | ☐ |
| 9. Because of your problem, are you afraid to leave your home without having someone accompany you? | ☐ | ☐ | ☐ |
| 10. Because of your problem, have you been embarrassed in front of others? | ☐ | ☐ | ☐ |
| 11. Do quick movements of your head increase your problem? | ☐ | ☐ | ☐ |
| 12. Because of your problem, do you avoid heights? | ☐ | ☐ | ☐ |
| 13. Does turning over in bed increase your problem? | ☐ | ☐ | ☐ |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yardwork? | ☐ | ☐ | ☐ |
| 15. Because of your problem, are you afraid people may think you are intoxicated? | ☐ | ☐ | ☐ |
| 16. Because of your problem, is it difficult for you to go for a walk by yourself? | ☐ | ☐ | ☐ |
| 17. Does walking down a sidewalk increase your problem? | ☐ | ☐ | ☐ |
| 18. Because of your problem, is it difficult for you to concentrate? | ☐ | ☐ | ☐ |
| 19. Because of your problem, is it difficult for you to walk around your house in the dark? | ☐ | ☐ | ☐ |
| 20. Because of your problem, are you afraid to stay home alone? | ☐ | ☐ | ☐ |
| 21. Because of your problem, do you feel handicapped? | ☐ | ☐ | ☐ |
| 22. Has your problem placed stress on your relationship with members of your family or friends? | ☐ | ☐ | ☐ |
| 23. Because of your problem, are you depressed? | ☐ | ☐ | ☐ |
| 24. Does your problem interfere with your job or household responsibilities? | ☐ | ☐ | ☐ |
| 25. Does bending over increase your problem? | ☐ | ☐ | ☐ |

## Hospital Anxiety and Depression Scale (HADS)

**Tick the box beside the reply that is closest to how you have been feeling in the past week.**
**Don't take too long over you replies: your immediate is best.**

| D | A | | D | A | |
|---|---|---|---|---|---|
| | | **I feel tense or 'wound up':** | | | **I feel as if I am slowed down:** |
| | 3 | Most of the time | 3 | | Nearly all the time |
| | 2 | A lot of the time | 2 | | Very often |
| | 1 | From time to time, occasionally | 1 | | Sometimes |
| | 0 | Not at all | 0 | | Not at all |
| | | | | | |
| | | **I still enjoy the things I used to enjoy:** | | | **I get a sort of frightened feeling like 'butterflies' in the stomach:** |
| 0 | | Definitely as much | | 0 | Not at all |
| 1 | | Not quite so much | | 1 | Occasionally |
| 2 | | Only a little | | 2 | Quite Often |
| 3 | | Hardly at all | | 3 | Very Often |
| | | | | | |
| | | **I get a sort of frightened feeling as if something awful is about to happen:** | | | **I have lost interest in my appearance:** |
| | 3 | Very definitely and quite badly | 3 | | Definitely |
| | 2 | Yes, but not too badly | 2 | | I don't take as much care as I should |
| | 1 | A little, but it doesn't worry me | 1 | | I may not take quite as much care |
| | 0 | Not at all | 0 | | I take just as much care as ever |
| | | | | | |
| | | **I can laugh and see the funny side of things:** | | | **I feel restless as I have to be on the move:** |
| 0 | | As much as I always could | | 3 | Very much indeed |
| 1 | | Not quite so much now | | 2 | Quite a lot |
| 2 | | Definitely not so much now | | 1 | Not very much |
| 3 | | Not at all | | 0 | Not at all |
| | | **Worrying thoughts go through my mind:** | | | **I look forward with enjoyment to things:** |
| | 3 | A great deal of the time | 0 | | As much as I ever did |
| | 2 | A lot of the time | 1 | | Rather less than I used to |
| | 1 | From time to time, but not too often | 2 | | Definitely less than I used to |
| | 0 | Only occasionally | 3 | | Hardly at all |
| | | | | | |
| | | **I feel cheerful:** | | | **I get sudden feelings of panic:** |
| 3 | | Not at all | | 3 | Very often indeed |
| 2 | | Not often | | 2 | Quite often |
| 1 | | Sometimes | | 1 | Not very often |
| 0 | | Most of the time | | 0 | Not at all |
| | | | | | |
| | | **I can sit at ease and feel relaxed:** | | | **I can enjoy a good book or radio or TV program:** |
| | 0 | Definitely | 0 | | Often |
| | 1 | Usually | 1 | | Sometimes |
| | 2 | Not Often | 2 | | Not often |
| | 3 | Not at all | 3 | | Very seldom |

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

# The Dizziness Symptom Profile

The following pages contain statements with which you can agree or disagree. To what extent do you personally agree or disagree with these statements in regards to your dizziness? Use the following scale: 0 = Strongly disagree, 1 = Disagree, 2 = Not sure, 3 = Agree, 4 = Strongly Agree

| | | Strongly Disagree | | Not Sure | | Strongly Agree |
|---|---|---|---|---|---|---|
| 1 | My dizziness is intense but only lasts for seconds to minutes. | 0 | 1 | 2 | 3 | 4 |
| 2 | I have had a single severe spell of spinning dizziness that lasted days or weeks. | 0 | 1 | 2 | 3 | 4 |
| 3 | I have spells where I get dizzy and also have irregular heartbeats (palpitations). | 0 | 1 | 2 | 3 | 4 |
| 4 | I hear my voice more loudly in one ear compared to the other. | 0 | 1 | 2 | 3 | 4 |
| 5 | I am unsure of my footing when I walk outside. | 0 | 1 | 2 | 3 | 4 |
| 6 | I get dizzy when I turn over in bed. | 0 | 1 | 2 | 3 | 4 |
| 7 | I get dizzy when I am in open spaces and have nothing to hold onto. | 0 | 1 | 2 | 3 | 4 |
| 8 | I have a roaring sound in one ear only before or during a dizziness attack. | 0 | 1 | 2 | 3 | 4 |
| 9 | I am depressed much of the time. | 0 | 1 | 2 | 3 | 4 |
| 10 | I lost hearing in one ear after an attack of spinning dizziness. | 0 | 1 | 2 | 3 | 4 |
| 11 | I had a big dizzy spell that lasted for days where I could not walk without falling over. | 0 | 1 | 2 | 3 | 4 |
| 12 | I get dizzy when I sneeze. | 0 | 1 | 2 | 3 | 4 |
| 13 | There are times when I get dizzy and also have a headache. | 0 | 1 | 2 | 3 | 4 |
| 14 | I get dizzy when I strain to lift something heavy. | 0 | 1 | 2 | 3 | 4 |
| 15 | I get short-lasting, spinning dizziness that happens when I bend down to pick something up. | 0 | 1 | 2 | 3 | 4 |

# The Dizziness Symptom Profile

| | | Strongly Disagree | | Not Sure | | Strongly Agree |
|---|---|---|---|---|---|---|
| 16 | My hearing gets worse in one ear before or during a dizziness attack. | 0 | 1 | 2 | 3 | 4 |
| 17 | I had a single constant spell of spinning dizziness that lasted longer than 2-3 days. | 0 | 1 | 2 | 3 | 4 |
| 18 | When I get a headache I am very sensitive to sound (I try to find a quiet place to rest). | 0 | 1 | 2 | 3 | 4 |
| 19 | I get short-lasting, spinning dizziness that happens when I go from sitting to lying down. | 0 | 1 | 2 | 3 | 4 |
| 20 | I can trigger a dizzy spell by placing my head in a certain position. | 0 | 1 | 2 | 3 | 4 |
| 21 | I had a spell of spinning dizziness that lasted for days or weeks after I had a cold or flu. | 0 | 1 | 2 | 3 | 4 |
| 22 | I have a feeling of fullness or pressure in one ear before or during a dizziness attack. | 0 | 1 | 2 | 3 | 4 |
| 23 | I get headaches that hurt so badly that I am completely unable to do my daily activities | 0 | 1 | 2 | 3 | 4 |
| 24 | I have spells where I get dizzy and it is difficult for me to breathe. | 0 | 1 | 2 | 3 | 4 |
| 25 | I have a sensation of dizziness or imbalance daily or almost daily. | 0 | 1 | 2 | 3 | 4 |
| 26 | My vision changes before a headache begins. | 0 | 1 | 2 | 3 | 4 |
| 27 | I am unsteady on my feet all the time. | 0 | 1 | 2 | 3 | 4 |
| 28 | I am anxious much of the time. | 0 | 1 | 2 | 3 | 4 |
| 29 | When I cough I get dizzy. | 0 | 1 | 2 | 3 | 4 |
| 30 | When I get a headache I am very sensitive to light (I try to find a dark room to rest). | 0 | 1 | 2 | 3 | 4 |
| 31 | I feel dizzy all of the time. | 0 | 1 | 2 | 3 | 4 |

**CONSENT FOR TESTING**

Please remember that proper identification of the cause of your dizziness and balance symptoms is important to determine the best course of treatment. All testing ordered is considered safe, effective, reasonable and necessary.

Insurance providers only issue payment for services they determine to be "medically necessary," according to their policies. I understand that my insurance company may deny coverage for any of the following services:

**VIDEONYSTAGMOGRAPHY (VNG) (CPT codes: 92540, 92543, 92547) $375**

**CALORICS (CPT code: 92537) $115 (CPT code: 92538) $75**

Considered the "gold-standard" and consists of a series of balance tests used to evaluate the function of the inner ear balance system and its connections to the eyes and brain.

**AUDITORY BRAINSTEM RESPONSE (ABR) (CPT code: 92585 or 92586) $266**

A test used to evaluate the integrity of the inner ear and brain pathways for hearing

**ELECTROCOCHLEOGRAPHY (ECOG) (CPT code: 92584) $173**

A test used to evaluate electrical activity within the inner ear in response to sound and assesses whether increased pressure is present

I have been notified that my insurance company may deny payment for the services identified above. If my insurance company denies payment, I agree to be personally and fully responsible for payment.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature (or guardian) | Patient Name (print) | Date |

The following tests are growing rapidly worldwide but have been greatly limited in most practices by the lack of a health insurance mechanism to bill. *In our opinion, they are a vital part of the balance assessment and significantly expedite our ability to diagnosis your problem and effectively plan your treatment.*

**VESTIBULAR EVOKED MYOGENIC POTENTIAL (VEMP) (CPT code: 92517/92518 or 92519) $173**

A test used to evaluate the integrity of one portion of the inner ear balance system (otolith organs known as the saccule and utricle) and balance nerve function.

**VIDEO HEAD IMPULSE TEST (vHIT) (**CPT code: 92700) $266

A test used to evaluate how all six of your semicircular canals respond to everyday head movements

As these are non-covered services by health insurance companies at this time, I am responsible for the payment of these test at time of service. If it does become a covered service, we will submit the charges to your insurance company at that time.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature (or guardian) | Patient Name (print) | Date |

**A. Notifier: OAT**

**B. Patient Name:** **C. Identification Number:**

# Medicare Advance Beneficiary Notice of Noncoverage (ABN)

***(Only Complete if you have Medicare)***

**NOTE:** If Medicare does not pay for **D.92700 VEMP & vHIT** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare to not pay for the **D.92700 VEMP & vHIT**.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| 1. 92700 vHIT | Non-covered services: These tests are growing rapidly worldwide in use but have been greatly limited in most practices by the lack of mechanism to bill. In our opinion, they are a vital part of the balance assessment and significantly expedite our ability to diagnose your problem and effectively plan treatment | 1. $273 |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.92700 vHIT** listed above. **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.92700 vHIT** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.92700 vHIT** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.92700 vHIT** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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