Bridgewater
Balance & Hearing

103 Suburban Road · Suite 101-D
Knoxville, TN 37923
865-769-0283
bridgewatersh.com

Patient Instruction for EcochG, ABR, and VEMP Testing

The electrocochleography (EcochG), auditory brainstem response (ABR), and vestibular-evoked myogenic potentials (VEMP) tests are designed to give your physician information regarding the source of your otologic symptoms.

The EcochG test measures fluid levels within the inner ear.

The ABR evaluates the integrity of the auditory nerve up to the lower brainstem.

The VEMP assesses the vestibular nerve and part of the inner ear balance system.

The EcochG and ABR tests require that you are still and lying down with your eyes closed. The test CAN be completed if you fall asleep. An electrode will be placed on your forehead and earphones inside both ears. You will hear loud buzzing sounds alternating between your ears throughout the evaluation.

For the VEMP test, electrodes will be placed on each side of your neck and at the base of your neck. The testing is completed in several separate runs while the audiologist holds your head and neck up at an angle while you are lying down. You will hear loud thumping sounds in one ear at a time. Please notify your audiologist if you have significant neck problems prior to this assessment.

PLEASE ALLOW AT LEAST 1.5 HOURS FOR THESE TESTS

However, if you are also having other evaluations completed (e.g., Hearing Assessment, VNG, etc.), more time may be necessary. If you have questions about your appointment beginning and ending times, please contact our office for assistance.

As a courtesy to Bridgewater, it is important your appointment is confirmed 48 hours prior. If you do not attend this appointment, you will be responsible for a $125 no-show office visit fee.

PRE-TEST INSTRUCTIONS

Following these instructions is imperative to an accurate and reliable test result. Failure to comply with these instructions may result in rescheduling your appointment.

1. **Discontinue ALL medications 48 HOURS prior to your testing that you have taken LESS THAN 6 MONTHS EXCEPT those taken for your heart, blood pressure, diabetes, or seizures AFTER obtaining approval from your prescribing physician(s).**
2. **NO beverages containing alcohol for 48 HOURS prior to testing.**
3. **Do NOT consume a level of caffeine that is abnormal for you 1 DAY prior to testing.**
4. **NO tobacco use of ANY form on the day of testing.**
5. **Do NOT eat 2 HOURS prior to testing. If you must eat for health reasons, please eat lightly.**
6. **Your face should be thoroughly washed and clean of make-up of ANY kind (including lotions/creams, mascara, eye liner, eye shadow, foundation, powder, etc.)**
7. **Dress comfortably.**

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Patient Instructions for VNG Testing

The videonystagmography (VNG) test is designed to give your physician information regarding the source of your imbalance, dizziness, and/or vertigo. The VNG test has 3 main parts:

1. **Following a light with your eyes**
2. **Sitting and laying with your head and body in different positions**
3. **Irrigating each ear with warm and cool air.**

Eye movements and the inner ear are neurally connected and allow for proper balance. Your audiologist can determine the function of the inner ear by observing and recording your eye movements through the use of goggles that record and measure very fine eye movements.

Portions of the test may induce the sensation of vertigo (spinning), but this effect is brief and temporary. There is no pain or needle sticks from this test.

We recommend that you have someone drive you to and from your appointment in the event you experience vertigo from this assessment.

PLEASE ALLOW AT LEAST 1 HOUR FOR THIS TEST

However, if you are also having other evaluations completed (e.g., Hearing Assessment, EcochG, ABR, and VEMP), more time may be necessary. If you have questions about your appointment beginning and ending times, please contact our office for assistance.

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These are examples of medications you should not take **48 HOURS** prior to testing **IF YOU STARTED** taking them within the past 6 months:

1. **All pain medications, including:**
   - ○ Acetaminophen (Tylenol, Tylenol PM, etc.)
   - ○ Ibuprofen (Advil, Motrin, Excedrin, Midol, etc.)
   - ○ Aspirin
   - ○ Naproxyn (Aleve)
   - ○ Codeine
   - ○ Darvocet
   - ○ Migraine Medications

2. **All anxiety or depression medications, IF allowed by your physician, including:**
   - ○ Valium or Diazepam
   - ○ Ativan or Lorazepam
   - ○ Pamelor or Nortriptyline
   - ○ Compazine
   - ○ Xanax
   - ○ Prozac
   - ○ Zoloft

3. **All anti-dizzy medications, including:**
   - ○ Antivert or Meclizine
   - ○ Valium
   - ○ Phenergan
   - ○ Dramamine
   - ○ Scopolamine (Transderm patch)

4. **All diuretics or water pills, including:**
   - ○ Dyazide
   - ○ Maxide
   - ○ Neptazane
   - ○ Lasix

5. **All sleep aids, including:**
   - ○ Ambien
   - ○ Halcion
   - ○ Tylenol PM

6. **All sinus and allergy medications, including:**
   - ○ Antihistamines (Benadryl)
   - ○ Decongestants (Sudafed)

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Registration & Consent

Social Security #:			
Last Name:	**First Name:**	**MI:**	
Preferred Name:	**Date of Birth:**	**Age:**	
Sex: ☐ **Male** ☐ **Female**	**Home Phone:**	**Cell Phone:**	
Work Phone:	**Email Address:**		
Street Address:			
City:	**County:**	**State:**	**Zip:**
Who may we contact in case of an emergency?		**Phone:**	
Who may we thank for referring you to Bridgewater?			
Who is financially responsible for the bill?		**Phone:**	

I authorize Bridgewater Balance and Hearing, Inc. to release information requested with regard to processing my claims. ☐ **YES** or ☐ **NO**

I authorize Bridgewater to disclose any or all parts of my protected health information to the individuals listed below. I acknowledge this with my signature within the Patient's Benefit Assignment, Privacy Notice, and Contact Authorization below:

Contact Preference: ☐ **CONFIDENTIAL** ☐ **DO NOT CALL** ☐ **OKAY TO LEAVE MESSAGE** ☐ **E-MAIL**

The evaluation and treatment procedures by Bridgewater clinicians are professionally and ethically acceptable and offer no probable physical or psychological risk. Although procedures are expected to be of benefit, I understand that no guarantee of success can be expressed or implied. I agree to the scheduled procedures and understand I may discontinue the evaluation or treatment at any time.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. All registration information is correct to the best of my knowledge. I will notify Bridgewater Balance and Hearing, Inc. should the above information change.

PRIVACY NOTICE: I confirm that I have been given a copy of Bridgewater Balance and Hearing's Notice of Privacy Policies and understand my privacy rights.

Signature: _____ **Date:** _____

Guardian Signature (if Patient is a minor)**:** _____

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Financial Responsibility for the Cost of Service

Insured Name (Print Clearly)**:** _____ **Insured's Date of Birth:** _____

Please List Primary and Secondary Insurances Below:

Primary Insurance Company Name	**Member ID Number**	**Date of Birth**
Secondary Insurance Company Name	**Member ID Number**	**Date of Birth**

Name of Primary Care Physician: _____

SERVICES REQUESTED: AUDITORY, VESTIBULAR, AND/OR DIAGNOSTIC EVALUATIONS

I know that commercial and state sponsored insurances pay for healthcare. I know when I get health care, my doctor sends the charges to my insurance company for payment. I know I must show my ID card to all doctors and hospitals before I get health care. I know a co-payment is when I have to pay part of the bill each time I receive certain health care services. **I know that it is my responsibility to get all insurance authorizations in advance.**

PLEASE INITIAL EACH STATEMENT BELOW THAT APPLIES TO YOU:

☐ **I have Medicare, Medicaid, or TENNCARE. I asked for one or more of the health care service(s) listed below. I understand my insurance may not pay for it.**
**A physician referral is REQUIRED to bill Medicare.*

☐ **I have private commercial insurance. I asked for one or more of the health service(s) listed below. I understand my insurance may not pay for it.**

My doctor has told me how much of the health care service(s), listed below, I may have to pay.

Balances listed below may be added to any applicable deductibles. I must pay my balance in a timely manner in order for the discounted amount to remain in force.

The patient is also responsible for any balance listed as patient responsibility.

This is a legal and binding contract.

SERVICE	COST OF SERVICE	PATIENT BALANCE IS NOT TO EXCEED:
Specialist New Patient Office Visit	$125.00	$125.00
Audiometric (Hearing) Evaluation	$335.00	$215.00
Auditory Processing (APD) Evaluation	$1,275.00	$595.00
EcochG and ABR Evaluation	$850.00	$395.00
VNG Evaluation	$1,200.00	$595.00
Hearing Instruments**	As Indicated	The patient agrees to pay all balances

***If you request that Bridgewater Balance and Hearing bills your insurance company for hearing instruments, the PATIENT is responsible for all hearing aid balances over the actual insurance reimbursement amount of the devices.*

***If you request that Bridgewater Balance and Hearing files your claim, provider write-off and discount amounts are NOT applicable on hearing instrument purchases.*

***Patients that choose to purchase hearing instruments that EXCEED the amount of insurance coverage on their plan do so with the understanding that they agree to pay ALL BALANCES over the actual insurance reimbursement amount.*

By signing this paper, I agree to pay for the services listed above in a timely manner.

By signing this paper, I agree to pay for the services listed above in a timely manner.

Printed Name of the Responsible Person	**Signature of Member or Responsible Person**

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Record Release

I authorize Bridgewater Balance and Hearing to issue my hearing healthcare information to:

☐ **Physician(s):** _____

☐ **Insurance Company:** _____

☐ **Other(s):** _____

Patient Signature: _____ **Date:** _____

Release of Records from Another Healthcare Provider

I authorize a release of my hearing and balance records to Bridgewater Balance and Hearing from:

_____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Please Fax Records to:

☐ **Knoxville Office at 865-769-0281**

☐ **Sevierville Office at 865-429-0719**

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Please Provide a List of Your Current Medications

MEDICATION	DOSAGE	FREQUENCY	ROUTE *(e.g., via mouth)*

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Confidential Patient History

MEDICAL HISTORY

	YES	NO
Have you seen a doctor in the past 6 months? If yes, who have you seen? _____	☐	☐
Have you seen a doctor specializing in diseases of the ear (e.g., ENT)? If yes, who have you seen? _____ When? _____	☐	☐
Have you ever had your hearing tested? If yes, give a date: _____ By whom? _____	☐	☐
Do you have a heart condition? If yes, please explain: _____	☐	☐
Do you have a pacemaker or defibrillator?	☐	☐
Do you have any significant medical conditions (e.g., high blood pressure)? If yes, please explain: _____	☐	☐
Do you take medication every day? If yes, explain for what conditions: _____	☐	☐
Have you ever had any type of ear surgery or trauma? If yes, please explain: _____	☐	☐
Have you had head trauma? If yes, please explain: _____	☐	☐
Do you use tobacco in any form?	☐	☐
Do you experience significant sinus and/or allergy issues?	☐	☐

ABOUT YOUR EARS

	YES	NO		BOTH	RIGHT	LEFT
Deformity of the ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Tinnitus (ringing or buzzing of the ear)	☐	☐	If yes, which ears(s)?	☐	☐	☐
Fullness or stuffiness of the ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Pain in your ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Drainage from the ear (aside from ear wax)	☐	☐	If yes, which ears(s)?	☐	☐	☐
Acute or chronic dizziness	☐	☐				
Sudden or rapid change in your hearing sensitivity	☐	☐				
Excessive ear wax requiring removal by a physician	☐	☐				
Extreme sensitivity to loud sounds	☐	☐				

ABOUT YOUR HEARING

	YES	NO
Are you concerned that you have hearing loss? If yes, for which ear(s)? ☐ BOTH ☐ RIGHT ☐ LEFT If yes, how long have you had difficulty hearing? _____ If yes, which is your poorer ear? ☐ SAME ☐ RIGHT ☐ LEFT	☐	☐
Does anyone in your family have a hearing problem? If yes, what relationship? _____	☐	☐
Do you or have you ever worn a hearing aid? If yes, how do you think you may be helped? _____	☐	☐
Do you have difficulty understanding conversations in quiet?	☐	☐
Do you struggle to understand speech in the presence of background noise?	☐	☐
Do you have difficulty hearing on the telephone?	☐	☐
Have you been exposed to loud noises (e.g. gun fire, explosions, power tools, factory noise, machinery, lawn equipment, loud music, etc.)?	☐	☐
If yes, did you wear hearing protection?	☐	☐

Patient/Guardian Signature: _____ **Date:** _____

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Dizziness Questionnaire

Patient's Name: _____ **Date:** _____

PLEASE READ THROUGH THE ENTIRE QUESTIONNAIRE FIRST. THEN, CHECK "YES" OR "NO" TO DESCRIBE YOUR FEELINGS MOST ACCURATELY. ANSWER ALL QUESTIONS COMPLETELY—FILL IN ALL BLANKS.

	YES	NO
Do you experience chronic and/or acute dizziness? **If not, do not complete the following questions.** **If yes, proceed to the following questions.**	☐	☐
My dizziness is constant.	☐	☐
My dizziness comes in attacks. If in attacks, how often do they occur? _____ How long does your attack of dizziness last? _____ When did the dizziness first occur? _____ Are you completely free of dizziness/instability in between attacks? ☐ YES ☐ NO Does a change in body position initiate your attacks of dizziness? ☐ YES ☐ NO If yes, explain: _____ Do you have a warning that the dizziness is about to start? ☐ YES ☐ NO If yes, explain: _____ Do the attacks occur at a particular time of day (e.g., day or night)? ☐ YES ☐ NO If yes, explain: _____	☐	☐
Objects spinning or turning around you?	☐	☐
Sensation that you are spinning and your environment is stationary?	☐	☐
Light headedness or swimming sensation in your head?	☐	☐
Blacking, loss of consciousness, and/or confusion?	☐	☐
Tendency to fall? If yes, please explain, to what direction(s)? ☐ RIGHT ☐ LEFT ☐ FORWARD ☐ BACKWARD	☐	☐
Loss of balance when walking? If yes, to which direction do you veer? ☐ RIGHT ☐ LEFT	☐	☐
Headaches?	☐	☐
History of migraines?	☐	☐
Nausea and/or vomiting?	☐	☐
Do you know any possible cause of your dizziness? If yes, explain: _____	☐	☐
Do you know of anything that will stop your dizziness or make it better? If yes, explain: _____	☐	☐
Do you know of anything that will make your dizziness worse? If yes, explain: _____	☐	☐
Exposure to irritating fumes, paints, etc. at the onset of your dizziness?	☐	☐
Do you experience any tinnitus (ringing or buzzing in your ear) or change in your tinnitus when you are dizzy? If yes, explain: _____	☐	☐

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? IF YOU CHECK "YES," PLEASE INDICATE WHETHER YOU EXPERIENCE THAT SYMPTOM CONSTANTLY OR IN EPISODES WITH YOUR DIZZINESS.

Yes	No		CONSTANT	EPISODES
☐	☐	Double/Blurred Vision or Blindness	☐	☐
☐	☐	Numbness of Face or Extremities	☐	☐
☐	☐	Weakness/Clumsiness in Arms or Legs	☐	☐
☐	☐	Difficulty with Speech	☐	☐
☐	☐	Difficulty with Swallowing	☐	☐
☐	☐	Pain in the Neck of Shoulders	☐	☐
☐	☐	Do you have a follow-up appointment with your physician or otolaryngologist (ENT) already scheduled? If yes, please indicate the date and time: _____		

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

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