Bridgewater
Balance & Hearing

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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.

PRE-TEST INSTRUCTIONS

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7. **Dress comfortably.**

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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 Form

Patient Name:			DOB:
Preferred Name:			
Street Address:			
City:		State:	Zip:
Social Security #:			Gender: ☐ **Male** ☐ **Female**

Social Security # of Responsible Party/Insured:	DOB:
Address of Guarantor, if different:	

Home Phone:	Work Phone:	Cell Phone:	Carrier:
Email Address:			Spoken Language: **English Spanish Other**
Marital Status: **Single Married Separated Divorced Widowed**			Name of Spouse, *if applicable*:
If child, please list the name of the custodial parent/guardian:			
Employer:	**Part-Time**	**Full-Time**	**Retired**
Occupation:			
Emergency Contact:	Relationship to Patient:		Phone #:
Referring Physician Name:			Phone #:
Primary Care Physician Name:			Phone #:
Who may we thank for referring you to Bridgewater?			
Who is financially responsible for the bill?			Phone #:
Contact Preference: ☐ **Confidential** ☐ **Do Not Call** ☐ **OK to Leave Message** ☐ **Email**			

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Bridgewater to communicate with these entities regarding your healthcare and treatment):

- ☐ **Referring Physician**
- ☐ **Primary Care Physician**
- ☐ **Other Physician**
- ☐ **School**
- ☐ **Family Member**
- ☐ **Other**

Signature: _____ **Date:** _____

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

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Office and Financial Policies

Thank you for choosing Bridgewater Balance and Hearing for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Bridgewater is a participating provider with most all insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan. Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if Bridgewater is not a participating provider in your insurance plan) and whether or not you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Bridgewater cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file, when needed. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers often do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Bridgewater commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Bridgewater reserves the right to charge up to a $125 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. 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 for you come back later in the day if a later appointment is available or reschedule to another date and time.

Your co-payment will be collected at the time the diagnostic services are provided and balances will be billed after Bridgewater has obtained an explanation of benefits from your insurance. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply. Bridgewater accepts payment in the form of cash, checks, Visa, MasterCard, and Discover. There will be a $30 fee for all bounced or returned checks.

It is also the policy of Bridgewater that we maintain a credit card number on file when/if a payment plan has to be arranged. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Bridgewater reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us

_____ **I request Bridgewater Balance & Hearing submit a claim to my insurance company on my behalf, for services provided. I am aware insurance may not cover services provided, and I am financially responsible for the balance.**

Patient Signature: _____ **Date:** _____

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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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