PROFESSIONAL
HEARING CENTER
A Division of Ascentist Healthcare
Vestibular & Balance Disorders Clinic

Vestibular and Balance Appointment Test Instructions

- The test will take approximately 2 hours to complete, which includes testing and explanation of results.
- Please arrive 15 minutes early to complete paperwork and ensure enough time for your appointment.
- The testing involves evaluation of eye movements. Please refrain from wearing eye and face makeup, as you will be asked to remove for the testing for accurate results.
- Please avoid taking medications for dizziness (specifically Meclizine and Antivert) 24-48 hours prior to the appointment to ensure accurate testing.
    - **Do not discontinue any other medications (such as blood pressure medications).**
- Eat a light, bland meal prior to testing as some testing may increase your dizziness or nausea. Avoid excessive caffeine or alcohol intake.
- Your testing may require assessments that are not covered by your insurance. We will bill your insurance first for any tests required for your diagnosis.

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PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. Although not covered by your health insurance, these services are an important part of your overall evaluation and care, and we recommend that you receive these services in order to make an accurate diagnosis. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services with an **out-of-pocket cost due prior to your appointment** are listed below**:**

- **$150** - Video Head Impulse Test (vHIT) - evaluation of six semicircular canals (balance organs) and both branches of the vestibular nerve. This test helps us make a diagnosis for the site of origin of your dizziness problem and make appropriate treatment recommendations.

The services that *may be recommended and performed* during the appointment are listed below:

- **$25** - Standing balance assessment and interpretation
- **$75** - Saccades and Saccadometry - advanced test of eye movement function and brain-eye connections
- **$150** - Additional tests post-head injury/concussion (additional oculomotor, vestibular-ocular reflex, questionnaires, and balance tests)
- **$25** - Positional Vertigo Treatment

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*

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

Question	**Yes**	**Sometimes**	**No**
Does looking up increase your problem?			
Because of your problem, do you feel frustrated?			
Because of your problem, do you restrict your travel for business or recreation?			
Does walking down the aisle of a supermarket increase your problem?			
Because of your problem, do you have difficulty getting into or out of bed?			
Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?			
Because of your problem, do you have difficulty reading?			
Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?			
Because of your problem, are you afraid to leave home without having someone with you?			
Because of your problem, have you been embarrassed in front of others?			
Do quick movements of your head increase your problem?			
Because of your problem, do you avoid heights?			
Does turning over in bed increase your problem?			

Because of your problem, is it difficult for you to do strenuous housework or yard work?			
Because of your problem, are you afraid people may think you are intoxicated?			
Because of your problem, is it difficult for you to go for a walk by yourself?			
Does walking down a sidewalk increase your problem?			
Because of your problem, is it difficult for you to concentrate?			
Because of your problem, is it difficult for you to go for a walk around your house in the dark?			
Because of your problem, are you afraid to stay home alone?			
Because of your problem, do you feel handicapped?			
Has your problem placed stress on your relationship with members of your family or friends?			
Because of your problem, are you depressed?			
Does your problem interfere with your job or household responsibilities?			
Does bending over increase your problem?			

Reference: The Development of the Dizziness Handicap Inventory Gary P. Jacobson, Ph.D.; Craig W. Newman, Ph.D. Arch Otolaryngol Head Neck Surg. 1990; 116(4):424–427

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____