USF
UNIVERSITY OF
SOUTH FLORIDA

Hearing Clinic
Phone: (813) 974-8804
Fax: (813) 905-9819
Email: hearingclinic@usf.edu

Thank you for choosing the USF Hearing Clinic. We would like to provide you with a few items to prepare for your upcoming visit with us.

Before your appointment

- Directions to the clinic are available in your new patient paperwork.
- Please have all new patient paperwork filled out and bring your driver's license, insurance card, and list of medications.
- If you are unable to complete the paperwork before the appointment, please arrive 30 minutes before your appointment.
- The red pass will be for your vehicle. You should park in a green RESERVED PSY/CSD spot and display the red parking pass on your dashboard. If you will be parking in the handicapped spaces, you will still need to display the red pass.

Your appointment is scheduled for:

_____

If you are not able to make your appointment, please call 813-974-8804 to cancel.

We look forward to seeing you soon!

3711 USF Laurel Drive Tampa FL 33620

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Hearing Clinic
(813) 974-8804
(813) 974-0822 - FAX

PATIENT INSTRUCTIONS FOR BALANCE ASSESSMENT TESTING:

An ENG/VNG has been ordered by your physician to help determine the cause of your dizziness or balance problem. The procedure is painless, and will last 60-90 minutes.

The **VNG/ENG** helps us to check the vestibular (inner ear balance) system as well as the pathways in the central nervous system responsible for connecting the inner ear, eye movement, and the brain, which are essential for your sense of balance. During the test, eye movements will be recorded while you follow lights and lay in different positions, and while warm and cool water or air are introduced into each ear canal. Recordings will either be made with electrodes, which are placed on the face (ENG), or by infrared goggles (VNG).

In order to obtain accurate results, please review and follow the instructions carefully:

- Get a full-night's sleep before the test so that you come fully rested.
- Wear comfortable clothing (preferably slacks) as you will be lying on a table.
- **Do not** wear any makeup, including mascara and eye liner, or facial lotions.
  - These can interfere with proper recordings.
- If you wear glasses or contacts, please bring them.
- Medications greatly influence test results. For 48 hours prior to your test, **DO NOT TAKE ANY OF THE FOLLOWING**:
  - Antihistamines/Decongestants: (Benadryl, Dimetapp, Triaminic, Claritin, etc...)
  - Sedatives/Sleeping Pills: (Halicion, Restoril, etc...)
  - Tranquilizers: (Valium, Librium, Atarax, Serax, etc...)
  - Pain relievers/Analgesics/Narcotics: (Aspirin, Codeine, Demerol, Percocet, etc...)
  - Stimulants/Amphetamines/Appetite Suppressants
  - Anti-nausea/Anti-Dizziness Medication: (Antivert, Meclizine, Dramamine, Diuretics, etc...)
- Vital medications **SHOULD NOT** be stopped. Continue to take your medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.
- Refrain from consuming alcoholic beverages for 48 hours before the test.
- **Do not** drink coffee, tea, soda, or any other caffeinated beverage for 48 hours prior to the test.
- **Do not** eat or drink for 4 hours prior to your test. If you are diabetic or prone to lightheadedness, you may have a small, light meal, or glass of juice.
- **Bring someone** along with you who can drive you home as this test may leave you with short-lived feelings of imbalance.

If you have any questions about the test/s, or about instructions, please call and talk to your Physician.

PLEASE COMPLETE THE PATIENT HISTORY FORM ON PAGES 2 AND 3

PATIENT HISTORY FORM

Name:_____ Age:_____

Part I

YES	NO	Do you have any latex/adhesive allergies?
YES	NO	Do you have equal visual perception in both eyes? If no, which is better?

[Please circle YES or NO]

Have you fallen two or more times in the past 12 months? YES NO

Have you had any falls in the past 12 months requiring medical attention? YES NO

Do you currently use any tobacco products? YES NO

Part II

Circle all that apply.

1. Describe what you are experiencing.

Spinning	Lightheaded	Passing out	Drunk/Fuzzy Feeling
Swimming Sensation	Imbalance	Motion Sickness	Headaches
Confusion	Double vision	Blurred vision	Neck Pain
Weakness in arms or legs	Numbness of face or extremities		Nausea or vomiting

Other (please explain):_____

2. When did these episodes begin? (be as specific as possible)

_____

3. How long does your dizziness/imbalance issues last?

Few Seconds	Seconds to minutes	Minutes to several hours
Hours to days	Continuous	

4. How often do you get dizzy?

Daily Weekly Monthly

5. Has the dizziness changed since the first episode? Yes NO

If Yes: Better Worse Shorter Longer

6. When do these episodes occur?

Standing up	Head movements	Sneezing	Straining
Rolling over in bed	Stress	Diet	Loud sounds

7. Do any of the following occur with your typical attacks?
   Hearing loss Tinnitus Headaches Facial numbness Anxiety
   Change in vision Pain

8. I have the following medical conditions:
   Diabetes Strokes Hypertension Coronary Artery Disease
   Seizures Migraines Vision problems Psychiatric

9. I have the following ear related problems:
   Hearing Loss Tinnitus Aural fullness Ear Pain Ear Infections

10. Does anyone in your family have:
    Migraines Meniere's disease Neurologic disorder Anxiety/Depression
    Hearing loss Motion Sickness

Part III

YES	NO	Do you use tobacco? How Often:
YES	NO	Do you use alcohol? How Often:
YES	NO	Do you use caffeine-containing beverages? How many cups per day:
YES	NO	Were you exposed to irritating fumes, paints, etc. at the onset of dizziness?
YES	NO	Did you suffer from motion sickness before age 12?
YES	NO	Did you ever injure your head? If so when?

Part IV

YES	NO	Have you taken any medications in the past for dizziness? Is so, what kind?

Medications: (Internal use only)

_____ Medications on file in EPIC _____ Copy provided by patient

PATIENT AUTHORIZATION REGARDING RESEARCH STUDIES

Participation in Research Projects

Patients may be asked by researchers in the department if they would be interested in participating in a research study pertaining to their condition. When contacted, patients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. **Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below:**

_____ Initial if you do **NOT** wish to be contacted with opportunities to participate in research.

Your signature verifies that you are understand the above information.

Signature:_____ Date:_____

Patient or Authorized Representative/Legal Guardian

USF HEALTH

CONDITIONS OF TREATMENT BY UNIVERSITY OF SOUTH FLORIDA (USF) COLLEGE OF MEDICINE

Permission for Treatment: Permission is hereby granted for physicians, residents, employees or agents of the USF College of Medicine ("USF Physicians Group") (collectively, the "Provider") to render the patient named below such medical and surgical treatment as is deemed necessary.

Authorization for Release of Information: The Provider (through its employees or contracted copying services) may disclose the patient's medical record and account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.
3. Other treatment providers within the USF College of Medicine/USF Physicians Group. (The USF Medical Clinics combine all records pertaining to each individual patient in one file. Therefore, in the event a patient is seeing more than one Provider within the USF College of Medicine/USF Physicians Group, each Provider will have access to the records created by every other Provider for that patient.)

Financial Agreement: (Please initial as applicable)

_____ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to University Medical Service Association, Inc. all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

_____ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ **Self-Paying Patient.** I have been informed that the USF College of Medicine/USF Physicians Group does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

_____

Print Patient's Name

_____ _____

Signature (Patient, Patient Representative) Date

_____ _____

Signature (Witness) Date

_____ _____

Signature (Financially Responsible Party) Date

_____ _____

Signature (Witness) Date

USF HIPAA COVERED COMPONENT
ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

Effective August 1, 2015

By signing below, I acknowledge that I have been provided a copy of this Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

_____ _____

Signature of Patient (or Authorized Personal Representative) Date

_____ _____

Print Name of Patient (or Authorized Personal Representative) Authority of Personal Representative
(e.g., parent, legal guardian, health care surrogate)

DOCUMENTATION OF GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

The patient presented for his/her service on this date and was provided a copy of the Joint Notice of Privacy Practices and Notice of Health Care Arrangement. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment of receipt was not obtained because of the following reason(s):

- ☐ Patient refused to sign the Acknowledgement of Receipt.
- ☐ Patient was unable to sign or initial the Acknowledgement of Receipt.

_____ _____

Signature of employee completing this form Date

_____

Print name of employee

Medical Record Number: _____

Or Affix Patient Label:

Scan/File Original in the Medical Record

USF HEALTH

Patient Name:_____ MRN Number:_____

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race, ethnicity and language as part of information provided to the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use requirements. This information is required for all patients.

Accordingly, we are required to request that you indicate your racial background, ethnicity and primary language by indicating one of the following:

Race

___ American Indian/Alaska Native

___ Asian

___ Black

___ Native Hawaiian/Other Pacific Islander

___ White

___ Declined

___Unknown

Ethnicity

___ Hispanic or Latino or Spanish Origin

___ Not Hispanic or Latino or Spanish Origin

___ Declined

___ Unknown

Please note that you have the option of indicating "declined" above.

Language_____

Other required data to offer better service to you:

Preferred Method to Notify You of Upcoming Appointment (*if you currently subscribe to the FollowMyHealth patient portal, you will receive appointment reminders through this method*)

_____Cell Phone Number _____

_____Home Phone Number_____

_____E-Mail – E-Mail Address_____

_____Text Message – Phone Number to Text_____

_____Do Not Call Me

_____No Response

*DATE ENTERED:*_____*BY:*_____*(Initials)*

USF HEALTH

PRIOR EXPRESS CONSENT

FOR COMMUNICATIONS FOR DEBT COLLECTION AND PAYMENT PURPOSES

I expressly agree and consent that, in order for University Medical Service Association, Inc. ("UMSA"), and its agents and affiliates, to service my account including debt collection and payment purposes, UMSA, or any of its agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. UMSA, or any of its agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails, using any e-mail address I provide to UMSA. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

I have read this Consent and agree that UMSA may contact me as described above. I hereby affirm that either (i) I am the patient and sign this Consent of my own behalf, or (ii) if I am signing this Consent on behalf of the patient, I have reviewed this Consent with the patient and he/she has expressly authorized me to sign this Consent on his/her behalf.

_____ _____

Patientor Patient's Authorized Representative Date

_____

(Relationship to Patient)

Patient Refused to Sign

_____ _____

(Signature of USF Health Rep) Date

USF Health
Release of Information

13330 USF Laurel Drive, MDC 33, Tampa, FL 33612
Phone (813) 974-9818 Fax (813) 974-4280

Authorization to Release written and verbal communication of Medical Records, PHI, to Additional providers, family member, Friend and/or Organizations.

Patient Name: _____

DOB: _____ Medical Record Number _____

Password for verbal communication _____ (choose a password that you will share with the individuals you want us to verbally communicate with. We will request this password before releasing any information.)

I authorize release of PHI as defined under "HIPAA" as described on the below authorization form to the following person(s), family member, physician(s) and or organization(s):

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Name of authorized person(s) or Physician(s: _____

Relationship to Patient: _____

Street Address: _____

City, State and zip code: _____

Telephone number: _____

Fax number: _____

Purpose: _____

Date: _____

Signature of patient or personal representative _____

Printed name of patient or personal representative (circle one) _____

Relationship to patient giving representative authority to act for patient _____

Patient or personal representative was given a copy of this form ☐ Yes ☐ No

USFPG Staff member completing this process _____

Date _____

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USF HEARING CLINIC POLICIES

All services are provided under the supervision of licensed and certified audiologists.
Policies relating to patient responsibilities are outlined below:

Attendance: Regular attendance is a critical component in assuring effective treatment. There are many more individuals needing services than our Clinic can accommodate. We ask that you inform the Clinic as soon as possible if you are unable to make your appointment as it may be possible to make-up or reschedule. Cancellations will require at least two hours prior notification. If an appointment is not canceled at least two hours prior to the scheduled time, it will be considered a no-show. If excessive cancellations occur, they will be dealt with on an individual basis and may result in termination of Hearing Clinic services.

Promptness: We try very hard to accommodate all patients and make every effort to be punctual for your appointment. Therefore, appointments cannot be extended in cases of late arrival. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule. We ask that everyone try to arrive 10 minutes before their scheduled appointment to allow time to obtain parking permits and fill out any necessary paperwork.

Family Involvement: We welcome and encourage family members to attend appointments. We do ask that small children be supervised at all times. We are not able to provide childcare during patient appointments. In accordance with USF polices parents/guardians of minors and caregivers must be on-site while the patient is in our facilities.

Student Observation: The Clinic is part of the clinical education program for students in the Department of Communication Sciences and Disorders at the University of South Florida. Graduate students work directly with patients under the supervision of Clinical Instructors at all times. Students are also required to periodically observe a variety of appointments as part of their learning experience. Students are aware of their ethical responsibilities regarding confidentiality of information.

Video Recording: Sessions are sometimes recorded as a means of assessing progress, evaluating the effectiveness of therapeutic approaches, or as a tool in therapy or teaching. Students periodically review and discuss recordings with their Clinical Instructor. Patient's consent to being recorded and confidentiality is assured. Recordings or other information NEVER leave the facility without your written consent.

Release of Information: A file is established for each patient containing reports and information regarding services. We often work cooperatively with other community professionals in coordinating services. To protect the confidentiality of patient records, we require your written permission before we communicate in any form with others about aspects of your care. Authorization to Send/Receive Information forms are available through the Clinic office and remain valid for one calendar year from date of signature.

The University Clinic Setting: The Clinic calendar coincides with that of the University. You will be notified well in advance of Clinic closures during University breaks and holidays. Also, student clinicians usually alternate from one semester to the next.

Fees for Services: Fees are charged for Clinic services. Our fees are competitive with those charged at other agencies in the community. A fee schedule is available in the Clinic Office. The hearing clinic also reserves the right to charge a nominal fee for patients that fail to cancel their appointments in a timely manner.

Insurance: The Clinic can often bill your insurance company when services provided by the Clinic are included in your health care policy. Please note that not all hearing services are covered by insurance. The Clinic can help determine if your policy provides these benefits.

Payments: Payment must be made at the time of service. Check with the Clinic Services Representative should you have questions. The Clinic accepts cash, checks, and credit cards.

I have read and understand the above information. _____ _____

Patient/Parent/Guardian Signature Date

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Tobacco Use and Hearing and Balance Disorders

What do patients need to know?

Recent data from the Centers for Disease Control (CDC) report that 17.8% of American adults (age 18 or older) smoke. This translates into an estimated 42.1 million adults in the US alone. Cigarette smoking is the leading cause of preventable disease, responsible for 480,000 deaths a year (approximately 1/5).

Smoking increases the risk of:

- Coronary heart disease
- Stroke
- Cancer, including but not limited to:
  - Lung
  - Stomach
  - Leukemia
  - Bladder, kidney, cervix, colon
  - Kidney, liver, pancreas
  - Esophagus, trachea, larynx, throat, tongue

Smoking has been correlated with hearing loss, especially when combined with noise exposure!

To quit tobacco use:

It is recommended that all treatment options for smoking and or/ tobacco cessation be discussed with your physician. Some possible treatment recommendations from a physician may include:

- Individual or group counseling
- Behavioral therapies
- Medications for quitting that have been found to be effective include the following:
  - Nicotine replacement products
    - Over-the-counter
    - Prescription
  - Prescription non-nicotine medications

Helpful Resources:

Quitline Services

- Call 1-800-QUIT-NOW (1-800-784-8669) if you want help quitting. This is a free telephone support service that can help people who want to stop smoking or using tobacco.

Smokefree.gov

- http://smokefree.gov

American Cancer Society

- http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-toc

American Lung Association

- Call 1-800-LUNGUSA
- http://www.lung.org/stop-smoking/

** Cited from Audiology Quality Consortium 2016

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Directions to the USF CSD Hearing and Speech-Language Clinics

**Please do not use the mailing address: ~~4202 Fowler Ave.~~

Building Address: 3711 USF Laurel Dr, Tampa, FL 33612

From I-275 (Downtown Tampa or Airport Area)

- Exit I-275 to Fletcher Avenue (exit 52)
- Drive east on Fletcher Avenue, past Bruce B. Downs Blvd. to Magnolia Drive
- Turn right on Magnolia Drive and drive south
- Turn left at 2nd traffic light onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

From I-75 (from Areas North, South, or East of Tampa)

- Take Fletcher Avenue (exit 266) and drive west to Magnolia Drive
- Turn left on Magnolia Drive (at light) and drive south
- Turn left at 2nd traffic light, Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

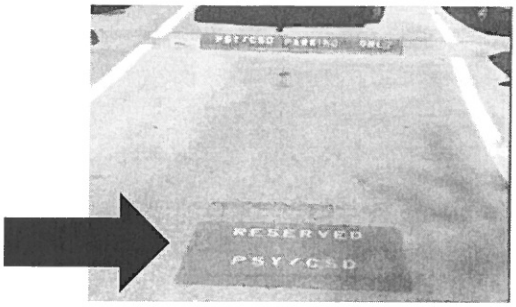
Fowler Avenue Entrance

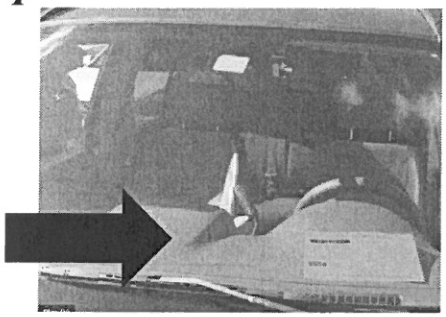
- Turn onto Leroy Collins Blvd. into USF campus main entrance
- Turn left at 1st stop light onto Alumni Drive
- Turn right onto Magnolia Drive
- Turn right onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Parking at USF CSD Hearing and Speech-Language Clinics

Please park in the reserved spots marked PSY/CSD in Lots 9A or 46.

Please display <u>RED</u> clinic parking pass on dashboard.





Lot 9A

- Lot 9A is located past the building on the Left (assigned reserved parking spaces are closest to the Psychology Building). When you exit your car, you will want to head back to the CSD Building which will be on your left.

Lot 46

- Additional parking is available in lot 46, which is located past the building and playground on the Right. Once you enter the parking lot stay to the right, closest to the playground and continue to keep right. This parking lot has several sections (assigned reserved parking spaces are located at the farthest end from where you entered, back towards Citrus Drive.) When you exit your car, please enter the CSD building from the closest doors and walk down the hallway past the bathrooms and towards the sliding doors.

<u>The Hearing Clinic</u> is located on the first floor of the Communication Sciences & Disorders Building and <u>The Speech Clinic</u> is located on the second floor.

<u>Red</u> arrows indicate where reserved spots are located in each parking lot

FIND YOURSELF LOST ON CAMPUS?
Call USF Visitor Services! 813-974-4607