



Medical Office Building, 4950 Norton Healthcare Blvd., Suite 200, Louisville, KY 40241  
UofL HealthCare Outpatient Center, 401 East Chestnut Street, Suite 710, Louisville, KY 40202  
Children's Hospital Foundation Building, 604 South Floyd Street, Suite 600, Louisville, KY 40202

Phone: 502.583.8303  
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## University Audiology Associates

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Welcome to University Audiology Associates. We appreciate the opportunity to provide you with comprehensive hearing services.

Please complete the enclosed forms and bring these completed forms with you on the day of your appointment.

Directions to our office are included in this mailing.

Please bring your insurance cards with you. All copays will be collected at the time of your visit. If your insurance plan requires a referral, it is your responsibility to obtain the referral prior to your appointment. Without your referral, it may be necessary to reschedule your appointment.

We contract with most insurance companies and we will bill those companies directly for services provided. For your convenience, we accept VISA and MasterCard.

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged \$25.00.

If we can provide assistance prior to your appointment, please do not hesitate to contact us. The staff at University Audiology Associates looks forward to serving your hearing healthcare needs.

*Affiliated with University Surgical Associates, PSC*



How did you hear about University Surgical Associates and/or your doctor?

- Internet     
  Radio     
  Direct Mail     
  Today's Woman     
  Louisville Magazine     
  Newspaper  
 Audience Playbill     
  Your physician     
  TV     
  Friend or word of mouth     
  Other \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor / PCP: \_\_\_\_\_

Address \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

### Patient Information

Patient's Last Name:		First Name:		M.I.	Patient's Social Security #:	
Street Address:					Age:	Date of Birth:
City:		State:	Zip:	Email Address:		Patient's Home Phone:
Employment or Student Status (if not a minor): Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Name of School: _____				Gender: (circle one) Male Female		Patient's Cell Phone:
Marital Status: S M D W		Patient's Employer:			Patient's Occupation:	
Patient's Work Phone & Ext#:		Employer's Address:			Date Employment Started:	
Spouse's Date of Birth:		Spouse's Name:			Spouse's Social Security #:	
Spouse's Work Phone:		Spouse's Employer:			Spouse's Occupation:	

NOT NEEDED IF A

### Responsible Party / Child's Parent Information

Responsible Party or Father's Name:			Responsible Party or Mother's Name:		
Social Security #:	Date of Birth:	Relationship to Patient:	Social Security #:	Date of Birth:	Relationship to Patient:
Employer:		Work Phone & Ext:	Employer:		Work Phone & Ext:
Home Address if different from Patient's:			Home Address if different from Patient's:		
City, State & Zip:		Phone:	City, State & Zip:		Phone:

### Primary Insurance

**PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.**

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

### Secondary Insurance

**PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.**

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

### Emergency Contact

**SOMEONE WITH A DIFFERENT PHONE NUMBER**

Name:	Phone Number:	Relationship to Patient:
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**RELEASE OF INFORMATION:** I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to University Surgical Associates P.S.C. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection.

Signature – Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

USA Doctor \_\_\_\_\_

Registrar \_\_\_\_\_

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following policy. If you have any questions, please feel free to discuss them with our staff.

## **YOUR INSURANCE**

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. For elective surgery you will be contacted to arrange for payment of the coinsurance and deductible. In the event your health plan determines a service to be “not covered” or you have “no insurance coverage”, you will be responsible for the complete charge. We will also bill your health plan for all services we provide in the hospital. We will be glad to establish a payment plan to meet your needs.

## **MINOR PATIENTS**

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

## **CANCELLATION/NO SHOW POLICY**

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged \$25.00.

## **SUPPLIES POLICY**

If we know there are supplies involved we will try to alert you of our charges before you come for your scheduled appointment. Your insurance may deny payment for this \_\_\_\_\_ service/supply. The patient/responsible party understand that this charge may be non covered and will be responsible for these charges at the time of service.

## **MEDICAL RECORD POLICY**

When requesting disability forms to be completed we will require a \$25.00 payment for the initial form and a \$10.00 payment for follow-up forms in advance of their completion.

## **PRESCRIPTION POLICY**

We ask that you call in your refill request for prescriptions during the hours of 9:00 am – 3:00 pm Monday thru Friday only. Prescription refills from 3:00 pm Friday – 9:00 am Monday are not available.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-responsible Party

\_\_\_\_\_  
Please Print the Name of the Patient

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Physician Name: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Birth Hospital: \_\_\_\_\_

Enrolled in First Steps? Yes No If yes, Service Coordinator: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Relationship to the child: \_\_\_\_\_

What specific concerns are there regarding this child's hearing?

Has this child ever had a diagnostic hearing test before? Yes No

Do you think this child has a hearing problem? Yes No

Are there concerns about this child's speech development? Yes No

If so, please explain:

How many ear infections (or ear fluid) has this child had? None 1-3 4-6 more than 6

Has this child ever had ear surgery (or ear tubes?) Yes No

If so, when?

Doctor's Name: \_\_\_\_\_

Was the pregnancy and delivery with this child normal? Yes No

If not, please explain:

Newborn hearing screening results: Pass Fail Don't Know

**Please check any of the following that apply to this child:**

- 48 hours or longer in NICU
- Premature birth
- Jaundice at birth requiring treatment  
Bilirubin level (if known) \_\_\_\_\_
- Low birthweight (less than 3 lbs.)
- Breathing difficulties at birth  
Ventilator (how long?) \_\_\_\_\_
- Infection of baby or mother at birth  
(i.e. CMV, herpes, toxoplasmosis, rubella)
- Defects of face, head or neck
- Genetic disorder or syndrome
- Family history of permanent childhood hearing loss?  
loss? If so, who?  
What type of treatment was needed? (circle)  
Surgery Hearing Aids/Cochlear Implant
- Environmental / seasonal allergies
- Developmental delays
- ADD/ADHD
- Serious illness or injury
- Head Injuries
- Meningitis if yes, when: \_\_\_\_\_

Please list any medications your child takes regularly:

If this child is in school:

What school does he/she attend? \_\_\_\_\_ Grade level: \_\_\_\_\_

Are there concerns about this child's progress or behavior at school?

If yes, please explain:

What other information do we need to know about your child?

University Surgical Associates PSC  
401 East Chestnut St. Suite 710  
Louisville, KY 40202

## NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

### THIS NOTICE TELLS YOU HOW YOUR MEDICAL RECORD MAY BE USED AND SHARED AND HOW YOU MAY GET THIS INFORMATION.

PLEASE READ IT CAREFULLY.

#### OUR PLEDGE TO YOU

Your health information is something that University Surgical Associates PSC has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

#### WHAT IS THIS DOCUMENT?

This document, called a Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We must follow the terms of this notice.

#### WHO FOLLOWS THIS NOTICE

This notice is for University Surgical Associates PSC. Other separate health-care providers at the University of Louisville Medical Center also may provide you with health services. You might receive a notice of privacy practices from them, too. If you are seen in a hospital at the U of L Medical Center, it will give you a notice that covers medical information gathered during your visit there including the information created by University Surgical Associates PSC.

#### WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION.

**Treatment.** We will use and share your medical record for your care.

**Example:** Doctors, dentists, students, medical residents or other university workers may read your record to learn if a treatment is working. Your medical information also may be shared with doctors or dentists outside University Surgical Associates PSC to decide the best treatment for you.

**Payment.** We may use and share your medical information to be paid for the care and services we provided you.

**Examples:** We may contact your insurance company to learn if a service is covered. We may bill you or your insurance company for the services we provide.

**Health-care Operations.** We need to use and share your health information to run our health-care business. We may use or share your information for several reasons.

**Examples:** Our staff may use your medical information to make sure that you and other patients get the best possible care. Medical students may see the information as part of their training. Others on our staff may use it to make sure that billing is being done correctly. In certain special conditions, other health-care providers may get your information from us to run their businesses.

**Business Associates.** We may share your medical information with another company or organization, called a "business associate" that we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep it private.

**Example:** A company that submits bills on our behalf to your insurance company.

**Appointment Reminders.** We may contact you to remind you of an appointment or to change one. We may also let you know that it is time for a follow-up appointment or a regular check-up.

**Health-Related Benefits, Services and Treatment Alternatives.** We may tell you about interesting health-related benefits or services such as newsletters, announcements, possible treatments or alternatives.

**Assistance for special projects, services and research.** University Surgical Associates PSC relies on the kindness of the community to help us provide quality health care to this region. *Patients who share their experiences and suggest ways to work with us are giving back in a meaningful way.* Their information also helps us improve and expand our services. We may use or share limited information, called demographic information, and the date you received care, to ask for your help. We also may share this information with our related foundation or business associates so they can contact you. Your generosity helps us continue to be an outstanding provider of health-care services in this region.

**Required Disclosures.** The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, *we must share your information with the Secretary of the Department of Health and Human Services.* We will share your information if they ask for it as part of an investigation of a privacy violation. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

**Required by Law.** We must share medical information if federal, state or local law says so.

**Public Health and Safety.** We may share your medical information for public health reasons. These include:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- to your employer in certain limited instances.

**Abuse and Neglect.** The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

**Health Oversight Activities.** Certain health agencies are in charge of overseeing health-care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

**Legal Proceedings.** If a court or administrative authority orders us to do so, we may release your health records. We will only share the information required by the order. If we receive any other legal request, we may also release your health record. However, for other requests we will only release the information if we are told that you know about it, had a chance to object and did not.

**Law Enforcement.** We may share health information if a law enforcement official asks for it:

- to respond to a court order, warrant, summons or other similar process;
- to identify or locate a suspect, fugitive, material witness or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

**Coroners, Medical Examiners and Funeral Directors.**

We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

**Research.** We may share your medical record with researchers, without your permission, in very limited situations. In most cases, a researcher must submit his/her request to see your information to a special group called the Institutional Review Board (“IRB”). This group will decide if it should allow the researcher to use or share your information. Your medical information also may be used by or shared with researchers to prepare for research, but only under strict conditions. Under similar strict conditions, medical information about dead people can be used or shared.

**To Prevent a Serious Threat to Safety.** We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

**Special Governmental Functions.** We may share your medical information with:

**Authorized federal officials**

- for intelligence, counter-intelligence and other national security activities authorized by law; or
- to protect the president.

**Armed forces command authorities or the Department of Veteran’s Affairs**

- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

**Correctional facility or law enforcement official or agency**

- if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:
- help the correctional facility provide you with health care; or
  - protect the health and safety of you and/or others.

**Workers Compensation.** We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

**WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT.**

**Individuals Involved in Your Care or Payment for Your Care.** We may share medical information about you with your family members, friend or any other person you tell us who is involved in your medical care or who helps pay for it.

We may tell your family or friends your condition and that you are in one of our facilities. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

Usually you will have a chance to object to the sharing of this information.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.**

You have certain rights regarding your health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to the University Surgical Associates PSC 's Privacy Officer at the address given at the end of this notice.

**Right to Request Special Communications.** You have the right to ask us to contact you about medical matters in a certain way or at a certain place. We will follow all reasonable requests. Your request must tell us how you wish to be contacted.

**Right to Inspect and Copy.** You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health-care professional chosen by us to review why we turned you down. We will follow the reviewer's decision.

**Right to Request Changes.** If you believe the health information that we created is wrong or incomplete, you may ask us to change it. *You must provide a reason why you want the change.* We cannot take out or destroy any information already in your medical record. We also are not required to agree to make the change. If we do not agree to the change, you can write a letter about the changes. We will send you one back saying why we will not make the changes. You may then send another disagreeing with us. It will be attached to the information you wanted changed or corrected.

**Right to an Accounting of Disclosures.** We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. We do not have to track every time we share your health information with others. *Your*

*request must give a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.*

**Right to Request Restrictions.** You have the right to ask for a restriction or limitation on the medical information we use or share about you for payment, treatment or health-care operations and the information we may share with your family, friends or others involved in your care. We are not required to agree to your request. If we agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided.

**OTHER USES AND SHARING OF YOUR HEALTH INFORMATION**

All other uses and sharing of your health information will be done only with your written permission.

**CHANGES TO THIS NOTICE.**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. The revised notice will be available at any of the locations where University Surgical Associates PSC offers services.

**WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?**

If you have any questions about this notice or about how your health information is used or shared by us please contact the University Surgical Associates PSC 's Privacy Officer, Marcella Rumpel by e-mail at MRumpel@usapsc.com or by calling (502) 238-1326.

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If you believe your privacy rights have been violated, you may file a complaint with us.

To file a complaint, please contact the University Surgical Associates, PSC 's Privacy Officer at 401 East Chestnut St., Suite 710, Louisville, KY 40202. Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services.

***Your care will not be affected if you file a complaint, nor will any action be taken against you.***

**University Audiology Associates, PSC  
601 South Floyd Street Suite 600  
Louisville, KY 40202**

**SUMMARY OF NOTICE OF PRIVACY PRACTICES**

Each time you go to a doctor, hospital or other healthcare place, a record of that visit is made. Usually, this record contains your symptoms, the examination, test results, diagnosis, treatment given and a plan for further care or treatment. This information, which we call your medical record, is an important part of the health care we provide for you. Although this record belongs to the facility that treated you, the information in the notes is yours, and you have a right to this information. These notes are called "Protected Health Information."

Our practice has a Notice of Privacy Practices that explains your rights and the steps we take to protect your health information. This policy tells you in detail how we will use your health information. A copy of this notice will be on display in our waiting room. We are giving you a copy of this notice today to read and make sure you know your rights regarding privacy and access to your records.

I have received a copy of University Audiology Associates, PSC Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





### Pre-Test Instructions for Balance Testing

- Electronystagmography (ENG)*: this balance test consists of three parts. First, you will be asked to watch a series of lights on the wall. Next, you will be asked to turn your head and body in several different positions. Finally, your ears will be irrigated with warm and cool water to measure eye movements. Test time is 1 to 1½ hours.
- Rotary Chair*: eye movement is measured while you are seated in a slowly rotation chair in a darkened booth. A speaker system allows communication with the audiologist outside of the booth. Test time is 45 minutes.
- Posturography*: Ability to maintain balance is measured while standing on a platform. You will be asked to perform various tasks with your eyes open and closed. Test time is 30 minutes.

#### **INSTRUCTIONS**

- Do not eat or drink anything for a period of (3) hours before the time of the test.
- Do not drink any caffeinated beverages or use any tobacco on the day of the test.
- Do not wear make-up foundation, moisturizer or face cream the day of the test.

Certain medications can affect the results of these tests. In order to prevent this from happening, it will be necessary for you to not take the following medications for two days, (48) hours, before the time of your test appointment, unless your physician says you must use your medicines at all times. Please consult your physician if you have any questions regarding the following medications.

#### DRUGS NOT TO TAKE INCLUDE

ANTI-Nausea Medicine: Dramamine, Compazine, Bonine, Vontrol, Marezine, Phenergan, Thorazine

Anti-Vertigo Medicine: antivert, Ru-vert, Meclizine, Neurontin

Anti-Depressants, Tranquilizers: Valium, Librium, Atarax, Vistaril, Diazepam, Equanil, Miltown, Triavil, Serax, Etrafon, Ativan, Haldol, Elavil

Sedatives: Nembutal, Seconal, Dalmane, Doriden, Placidyl, Phenobarbital, Quaalude, Butisol, or any sleeping pills.

Analgesics-Narcotics: Codeine, Demerol, Dilaudid, Percodan, Penaphen, Tylenol w/ codeine

Anti-Histamines: Chlor-trimeton, Dimetane, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, or any over-the-counter cold remedies.

Anti-Seizure Medicine: Dilantin, Tegretol, Phenobarbital \*\*Please consult your physician

Alcohol of any quantity

Although these are simple tests, some people do experience dizziness. You may wish to have someone accompany you to the test to drive you home afterward. Please feel free to contact us at 583-3277 regarding any of these instructions or if you have any questions.

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_