Otology / Neurotology
Douglas A. Chen, M.D., F.A.C.S.
Todd A. Hillman, M.D.

Ralph Caparosa, M.D., F.A.C.S.
Emeritus (1924-2001)

Audiology

Julie Hobbs, M.A., CCC-A
Rhonda Tubbs, Au.D., CCC-A
Lawrence McGuinness, M.A., CCC-A
Denise Hoysack, Au.D., CCC-A
Emily Manley, Au.D., CCC-A

Vestibular Technician

Brian Morin, B.S.

Otologic Surgery

Neurotology

Skull Base Surgery

Vestibular Disorders

Audiology

Hearing Aid Dispensing

Cochlear Implants

Implantable Hearing Aids

Main Office:
420 East North Avenue, Suite 402
Pittsburgh, PA 15212
(412) 321-2480
FAX (412) 321-3229

8500 Brooktree Dr
Suite 110
Wexford, PA 15090

Med Health Services Building
200 James Place
Suite 406
Monroeville, PA 15146

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www.pittsburghear.com

Practice limited to the ear,
facial nerve and skull base.

Dear Patient:

We welcome you as a patient and appreciate the opportunity to provide medical care. Enclosed you will find our financial policy and forms which must be completed prior to your arrival in our office.

Our office participates in most major healthcare insurance plans. If a referral is required for your visit, we recommend that you contact your Primary Care Physician (PCP) as soon as possible. If your referral has not been received in our office, you may be asked to reschedule. **Co-Payment is due on the date of service.**

We try our best to maintain an efficient office schedule and to avoid any unnecessary delays or the need to reschedule. We ask for your assistance in the following:

- ***Plan to arrive 15 minutes early***
- ***Contact your insurance company to verify coverage for your visit***
- ***Complete the enclosed forms and bring with you the day of your visit***
- ***Bring copies of your medical records/ x-ray films or disks if available***
- ***Bring your current insurance card***
- ***Bring your photo ID (driver's license) or other form of identification***
- ***Complete list of all medications taken daily and dosages***
- ***Name, address, phone, fax, for your Primary Care Physician and/or referring physician for correspondence***
- ***Co-Payment due at the time of service*** *(*we accept cash, check, Mastercard, Visa, Discover, American Express)

We look forward to meeting you on ____

at _____________________ am pm

_____ Allegheny General ______ Wexford ______ Monroeville

Sincerely,

Douglas A. Chen, M.D.

Todd A. Hillman, M.D.

and Staff

Pittsburgh Ear Associates

Patient Information (please print)

Last Name First Initial	( ) Home Phone
Male ________	Marital Status- (circle): Married / Widow(er) / Single / Divorced / Separated
Female ______ Date of Birth	
Patient Street Address	Employer
City State Zip	( ) Work Number
Patient Social Security Number	Occupation
	Spouse Name Date of Birth
	Spouse Social Security #

(Please complete this information in full)

Referring Physician Information

First Name Last Name

Complete Street Address

City State Zip

( ) Phone Number

( ) Fax Number

Primary Care Physician Information

First Name Last Name

Completed Street Address

City State Zip

( ) Phone Number

( ) Fax Number

If patient is a minor, full name of parent(s):

Mother's Name Birthdate SS#

Address

City State Zip

( ) Phone Number

Father's Name Birthdate SS#

Address

City State Zip

( ) Phone Number

Emergency Contact Person:

Name of Contact ______________________ Relationship to patient ______________________

Street Address ______________________ (______) Phone Number ______________________

City State Zip ______________________

Insurance Information:
Insurance #1 (Primary coverage)

Patient Name ______________________ Date of Birth __________ Social Security # __________

Subscriber (Name of person Ins. is under) ______________________ Date of Birth __________ Social Security # __________

Relationship to the patient ______________________ Group Number __________ ID Number __________

Full Name of Insurance Company ______________________

Do you have additional insur. coverage?
If yes, please provide information
Insurance #2 (Secondary Coverage)

Subscriber (Name of person Ins. is under) ______________________ Date of Birth __________ Social Security # __________

Relationship to the patient ______________________ Group Number __________ ID Number __________

Full Name of Insurance Company ______________________

Accident Information:
Is your visit due to an accident? ______________ Date of Accident ______________
Circle one: Work Auto Other______________________________
(Please Explain)

Work/Auto Related Accident-please complete

Employer Name or Insurance Company Name ______________________ (______) Phone Number ______________________

Address ______________________ Claim Number ______________________

City State Zip ______________________ Case Manager or Contact Person ______________________

GUARANTEE OF PERSON RESPONSIBLE FOR PAYMENT:

Patient Name: ___________________________________ I, the undersigned, hereby guarantee payment of charges for the above named patient.

Signature: X _____________________________________ Witness: X_________________________

Date: ____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to the above named of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due according to the office's regular charges for services provided. I understand that I am financially responsible for charges not covered by this authorization.

X: ____

Signature of Policyholder or Representative

MEDICARE SIGNATURE CARD:

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN);

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries of carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician to submit a claim to Medicare for payment to me.

X: ____ Date: _____________________________

Signature

MEDICAID: Statement to permit payment or Medicaid benefits to Provider (Physician):

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare or its intermediaries or carriers any information needed for this or related Medicaid claim. I request that payment of services to the physician furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

X: ____ Date: _____________________________

Signature

CONSENT TO RELEASE INFORMATION:

I hereby request and authorize Pittsburgh Ear Associates to contact my insurance company or provide my insurance company information that may be necessary for the company to process my medical claims. The information to be released will include my medical status and proposed treatment.

X: ____ X: _________________________________

Signature of Patient of Guardian Witness

____

Date

Please present your insurance cards to Receptionist

Pittsburgh Ear Associates, P.C.
420 East North Avenue Suite 402
Pittsburgh, PA 15212
412-321-2480

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I will be provided with a copy of Pittsburgh Ear Associates P.C. (the "practice") Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the **Health Insurances Portability and Accountability Act of 1996, (HIPPA)** that may be made by the Practice and of my rights and the Practice's legal duties with respect to my protected health information. ***I will have the opportunity to review the Notice and take a copy with me if I so choose.***

____
Patient's Name (Print)

____
Patient's Signature

____
Date

Patient Permission to Discuss Protected Healthcare Information

I, _________________________ hereby request to appoint a family member or friend to act on my behalf in discussing health information with my physician/audiologist or designated medical personnel at Pittsburgh Ear Associates.

____ __________________________
Name of Family Member/Friend Relationship to Patient

____ __________________________
Address Phone Number

____
City State Zip code

Are there any limitation on issues your personal representative may discuss ______ no ______yes

____
List Limitations

Do we have permission to leave a phone message regarding your test results with the following?:

_______ Answering machine _______ Voice Mail _______ Family Member ______ Cell Phone

_______ Only Myself (Check All That Apply) Cell Phone #: _______________

Pittsburgh Ear Associates, P.C.
420 East North Avenue Suite 402
Pittsburgh, PA 15212
412-321-2480

OUR FINANCIAL POLICY

1. Payment is due at the time of service unless arrangements have been made in advance with our office. We accept Visa, Discover, MasterCard, and American Express.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your claim if you assign the benefits to the doctor—in other words if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and **you are required to pay your co-payment at the time of your visit.**

4. If you are insured by a plan that we do not participate with, you are responsible for payment to us when services are rendered. We do not file claims for any non-par insurance plans.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be **"non covered", you will be responsible for the complete charge**. Payment is due at the time of service.

6. If you have a high deductible insurance plan, and you have not met the deductible for your policy period, payment is due at the time of your office visit or prior to your scheduled surgical procedure. Arrangements for payment will be made with you in advance once your benefits have been determined.

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

____

Signature of patient (or responsible party, if a minor) Date

PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF YOUR APPOINTMENT

Date: _______________ Name: ____________________________________ Age: __________

Current Medications:

Allergies to Medications:

Previous Surgery:

REVIEW OF SYSTEMS

AT THIS TIME DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:

Constitutional

Yes No fever or chills
Yes No weakness or fatigue
Yes No recent weight loss

Eyes

Yes No blurred vision
Yes No double vision

Ears, Nose, Mouth, and Throat

Yes No trouble hearing
Yes No tinnitus, noise or ringing in the ears
Yes No ear pain
Yes No ear infection or drainage
Yes No dizziness, vertigo, or unsteadiness
Yes No stuffy nose
Yes No frequent colds
Yes No hay fever
Yes No sinus trouble
Yes No frequent nosebleeds
Yes No frequent sore throats
Yes No pain near teeth or mouth
Yes No hoarseness or voice change
Yes No difficulty with swallowing
Yes No lumps in neck
Yes No swollen glands in neck
Yes No pains in the neck

Cardiovascular

Yes No heart trouble
Yes No palpitations
Yes No high blood pressure

Respiratory

Yes No cough
Yes No asthma or wheezing
Yes No shortness of breath

Gastrointestinal

Yes No heartburn or acid reflux
Yes No nausea or vomiting
Yes No diarrhea
Yes No ulcers

Genitourinary

Yes No frequent urination
Yes No painful urination

Musculoskeletal

Yes No joint pain or stiffness

Integumentary

Yes No skin rashes
Yes No excessive skin dryness/itchiness

Neurological

Yes No headaches
Yes No numbness in face, arms, or legs
Yes No seizures
Yes No weakness of arms or legs
Yes No blackouts or fainting
Yes No trouble speaking
Yes No confusion or memory loss

Psychiatric

Yes No nervousness or increased stress
Yes No sleep problem
Yes No excessive moodiness or worry

Endocrine

Yes No heat or cold intolerance
Yes No excessive thirst or urination

Hematologic

Yes No easy bruising or bleeding
Yes No anemia

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Allergic

Yes No hay fever or dust/mold allergy
Yes No food sensitivity or intolerance
Yes No chemical sensitivity

Past Medical History
DO YOU HAVE, OR HAVE YOU EVER HAD…..

Yes No Heart Disease (heart attack, angina, heart surgery, arrhythmia)
Yes No Diabetes
Yes No Lung Disease
Yes No High Blood Pressure
Yes No Thyroid Problems
Yes No Kidney Problems
Yes No Cancer
Yes No Liver and Gallbladder Trouble
Yes No Head Trauma
Yes No Stroke or TIA
Yes No Migraine Headaches
Yes No Seizure
Yes No Anxiety Disorder
Yes No Depression
Yes No Panic Attacks
Yes No Arthritis
Yes No Glaucoma
Yes No Macular Degeneration
Yes No Transfusion of Blood or Blood Products

Social History:

Occupation: Martial Status:

Children:

Yes No Do you use tobacco? _______packs/day ________years. Quit, how long ago? __________
Yes No Do you use alcohol? _______ drinks/day/ week/ weekend/ month
Yes No Do you use coffee, tea or caffeine containing beverages? ___________ cups/ day

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IF ANY BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING, PLEASE CIRCLE AND INDICATE WHICH RELATIVE:

Epilepsy Migraine Mental Illness Glaucoma

Diabetes Thyroid Anemia Bleeds Easily

Heart Disease Stroke High Blood Pressure

Cancer Hearing Loss

Patient Signature: ____

Reviewed by: ______________________________________ **M.D.**

DIZZINESS / IMBLANCE QUESTIONAIRE

Please complete this questionnaire and bring it with you to your appointment.

NAME: ______________________________________ DATE: _______________ AGE: ________

Please answer these questions about your dizziness/ imbalance. “Dizziness” is a broad term used to define many sensations.

A. When you are “dizzy” do you experience any of the following sensations?

Please read the entire list first. Then circle **Yes** or **No** to describe your feelings most accurately.

Yes No 1. Lightheadedness or swimming sensation in the head

Yes No 2. Blacking out or loss of consciousness

Yes No 3. Tendency to fall: To the right? To the left? Forward? Backward?

Yes No 4. Objects spinning or turning around you

Yes No 5. Sensation that you are turning or spinning inside, with outside objects remaining Stationary

Yes No 6. Loss of balance when walking: Veering to the right? Veering to the left?

Yes No 7. Headache

Yes No 8. Nausea or vomiting

Yes No 9. Pressure in head

Yes No 10. Other, please specify ____

B. Please answer these questions about your dizziness/ imbalance.

Circle **Yes** or **No** and fill in the blank spaces. **Answer all questions**

1. When did the dizziness/ imbalance first occur? ______________________________

2. My dizziness/ imbalance started?

Yes No Suddenly?

Yes No Gradually?

3. My dizziness/ imbalance is:

Yes No Constant?

Yes No In attacks?

4. If in attacks:

How often do they occur? ____

How long do they last? ____

Describe your **first** attack of dizziness ____

____

____

Yes No Do you have any warning when the attack is about to start? ____________________

____

Yes No Do they occur at any particular time of the day or night? ______________________

Are you completely free of dizziness between attacks? ________________________

When was the last attack? ____

Describe your **last** attack ____

____

____

5. Overall has your dizziness gotten better or worse since starting? _______________

____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

NAME: ____

Yes No 6. Do any other symptoms occur simultaneously with the dizziness such as nausea, vomiting, ringing in the ears, or ear pressure? Please explain. ___________________

____

____

Yes No 7. Does the dizziness occur only in certain position? If yes, what positions? _________

____

Yes No 8. Do you have any trouble walking in the dark?

Yes No 9. Does the dizziness occur only while standing or walking?

Yes No 10. When you are dizzy, must you support yourself when standing or walking?

Yes No 11. Do you know any possible cause for your dizziness? What? ___________________

____

12. Do you know anything that will:

Yes No Stop your dizziness or make it better? ____________________________________

Yes No Make your dizziness worse? ____

Yes No Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional Upset? Headache? Other? _______________)

Yes No 13. Were you exposed to any irritating fumes, paints, etc., at the onset of the dizziness?

Yes No 14. Have you ever injured your head or neck? Describe the accident _______________

____

Yes No 15. Have you ever fallen because of the dizziness? How many times? ______________

Yes No 16. Are you prone to motion sickness?

Yes No 17. Have you ever been treated with intravenous antibiotics such as Gentamicin, Streptomycin, etc. or chemotherapeutic drugs? If yes, which ones? _____________

____

Yes No 18. Has the dizziness affected the quality of your life?

Yes No 19. Have you ever seen a psychiatrist or psychologist for any reason?

Yes No 20. Are you legally disabled or in the process of determining disability?

C. Please answer these questions about your ears and hearing:

Check **Yes** or **No**, and circle which ear when necessary.

Yes No 1. Do you have difficulty hearing? Right Left Both

2. How long have you noticed the hearing loss?

Right ear ________________________________

Left ear ________________________________

Yes No 3. Do you have any noises in your ears? Right Left Both

Describe the noise ____

Yes No 4. Is the noise constantly with you?

Yes No 5. Does the noise occur only with the dizziness?

Yes No 6. Have you worked in a noisy environment or been exposed to loud noise?

What type of noise exposure?____

Yes No 7. Do you have pain in your ears? Right Left Both

Yes No 8. Do you have drainage from your ears? Right Left Both

Yes No 9. Do you have fullness of stuffiness in your ears? Right Left Both

Yes No 10. Have you had any surgery on your ears? Right Left Both

Yes No 11. List the date of the surgery, the reason, and the ear operated on _______________

____

Yes No 12. Do any members of your immediate family (parents, brothers, and sisters) have any diseases of the ear or central nervous system (e.g., brain tumors, multiple sclerosis, etc.) If yes, please specify ____

____