NEWPORT-MESA AUDIOLOGY
BALANCE & EAR INSTITUTE

500 Old Newport Boulevard
Suite 101
Newport Beach, CA 92663

949.642.7935 Phone
949.642.2950 Fax
dizziland.com

Patient Information (Please complete all entries.)

Patient Name (Last/First/Middle)	Sex M F	Date of Birth	Age	Social Security Number
Address (Street)	Marital Status Single Married Divorced Widowed			
	Driver's License Number			
Address (City / State / Zip)	Home Phone Number ( )		Cell Phone Number ( )	
E-mail Address	Preferred Method of Communication ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail			
Race ○ American Indian ○ Asian ○ Pacific Islander ○ African American ○ White ○ Hispanic ○ Other	Language ○ English ○ Spanish ○ Vietnamese ○ Other:			
Name of Employer	Occupation			
Employer's Address (Street / City / State / Zip)			Work Phone Number ( )	
Do you have a Power of Attorney? ○ Yes ○ No If yes, name:	Power of Attorney's Phone Number ( )			
Emergency Contact Name & Relation	Emergency Contact's Phone Number ( )			
Primary Care Physician	Primary Care Physician's Phone Number ( )			
Whom May We Thank For Referring You to Us?	Phone Number ( )			

Insurance Information - **We will request to scan your ID and insurance card(s).**

Primary Insurance (Fill out the Primary Insurance Subscriber's information below.)

Subscriber Name (Last/First/Middle)		Relationship to Subscriber ○ Self ○ Other:	Date of Birth
Insurance Name	ID Number	Group Number	Social Security Number
Employer	Occupation		Subscriber's Phone Number ( )
Employer's Address (Street /City / State / Zip)			Work Phone Number ( )

Secondary Insurance (Fill out the Secondary Insurance Subscriber's information below.)

Subscriber Name (Last/First/Middle)		Relationship to Subscriber ○ Self ○ Other:	Date of Birth
Insurance Name	ID Number	Group Number	Social Security Number
Employer	Occupation		Subscriber's Phone Number ( )
Employer's Address (Street /City / State / Zip)			Work Phone Number ( )

The above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

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Health Questionnaire

Please complete all entries.

Patient Name _____ **Date** _____

A. Reason for Visit: _____

_____

B. Medication: List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency

Pharmacy _____ Pharmacy Phone Number _____

May we contact your pharmacy? ◯ Yes ◯ No

C. Allergies to medications: _____

D. Surgical History/Hospitalizations: List all surgeries. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Condition/Illness/Surgery	Length

E. Social History: Please check appropriate box and give amount.

1. Do you smoke? ◯ Yes ◯ No How many packs per day? ☐ less than ½ ☐ ½-1 ☐ 1-3 ☐ 3+
2. Do you drink alcohol? ◯ Yes ◯ No How many drinks per day? ☐ 1 ☐ 2-5 ☐ 6+
3. Do you drink caffeine products? ◯ Yes ◯ No What kind? ☐ tea ☐ coffee ☐ soda

If you drink caffeine products, how many cups per day? ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4+

F. Symptom Review: Please select to indicate if you had had any of the following symptoms or diseases:

Neurological
- ☐ stroke
- ☐ migraine
- ☐ blackout spells
- ☐ weakness or paralysis
- ☐ terror/hand shaking
- ☐ head injury
- ☐ numbness/tingling sensations
- ☐ muscle pains
- ☐ significant arthritis
- ☐ muscle irritation/tenderness

ENT
- ☐ meningitis
- ☐ dry mouth
- ☐ headaches
- ☐ glaucoma
- ☐ itching eyes or nose
- ☐ hay fever
- ☐ sneezing or runny nose
- ☐ sinus trouble
- ☐ dry eyes
- ☐ eye disease or poor vision

Infectious
- ☐ AIDS
- ☐ HIV positive
- ☐ venereal disease
- ☐ syphilis
- ☐ gonorrhea
- ☐ tuberculosis
- ☐ chicken pox
- ☐ German measles
- ☐ mumps
- ☐ scarlet fever

Endocrine
- ☐ hormone therapy
- ☐ thyroid
- ☐ diabetes

Gastrointestinal
- ☐ constipation
- ☐ diarrhea
- ☐ ulcer
- ☐ heart burn
- ☐ liver disease
- ☐ pancreatitis

Respiratory
- ☐ pneumonia
- ☐ tuberculosis
- ☐ asthma
- ☐ chronic cough
- ☐ shortness of breath

Genitourinary
- ☐ kidney disease
- ☐ prostate problems
- ☐ kidney stones
- ☐ blood in urine

Psychiatric
- ☐ nervous breakdown
- ☐ depression
- ☐ chronic fatigue
- ☐ suicidal tendencies
- ☐ anxiety

Cardiovascular
- ☐ heart attack
- ☐ angina/chest pain
- ☐ any heart trouble
- ☐ heart murmur
- ☐ arrhythmia
- ☐ high blood pressure
- ☐ rheumatic fever

Hematology
- ☐ bleeding disorder
- ☐ anemia
- ☐ previous transfusions
- ☐ easy bruising

Gynecological
- ☐ pregnancy
- ☐ currently breast feeding
- ☐ vaginitis

Skin
- ☐ rashes
- ☐ blistering of skin
- ☐ eczema
- ☐ psoriasis
- ☐ sun sensitivity

General
- ☐ cancer

G. Family History: Select the following diseases which are common in your family or have occurred in any family member. Do not include family members by marriage or adoption.

- ☐ asthma
- ☐ auto immune disease
- ☐ bleeding disorder
- ☐ cancer
- ☐ dizziness
- ☐ diabetes
- ☐ hay fever
- ☐ hearing loss
- ☐ heart disease
- ☐ high blood pressure
- ☐ kidney disease
- ☐ Meniere's disease
- ☐ migraine
- ☐ surgical complications
- ☐ stroke
- ☐ tuberculosis
- ☐ vertigo

H. Ear Disease Please select Yes or No

- ○ Yes ○ No 1. Have you ever had your hearing tested?
- ○ Yes ○ No 2. Have you ever been to a doctor for your ear trouble?
- ○ Yes ○ No 3. Have you ever had ear or head surgery?
- ○ Yes ○ No 4. Have you ever worn or are currently wearing hearing aids?
- ○ Yes ○ No 5. Current symptoms include:
  - ☐ Allergies ☐ Dizziness ☐ Ear Drainage ☐ Ear Pain ☐ Cold ☐ Ear Pressure ☐ Ear Infection
- ○ Yes ○ No 6. Are you bothered by ringing noises?
- ○ Yes ○ No 7. Are you now taking more than a few aspirins a day?
- ○ Yes ○ No 8. Have you ever taken large doses of Aspirin, Bufferin, Emperin or Quinine?
- ○ Yes ○ No 9. Have you ever taken medications known to be damaging to your ears?
- ○ Yes ○ No 10. Have you ever received injections of any antibiotics of the mycin family?
- ○ Yes ○ No 11. Have you ever suffered a severe head injury or concussion?
- ○ Yes ○ No 12. Do you have more difficulty understanding speech today than you did five years ago?
- ○ Yes ○ No 13. Do you have difficulty listening to music?
- ○ Yes ○ No 14. Did you ever or do you now participate in (or use) any of the following: (select all that apply):
  - ☐ Motorcycling ☐ Snowmobiling ☐ Musical instruments ☐ Farm equipment
  - ☐ Target shooting ☐ Auto racing ☐ Private airplanes ☐ Chainsaws
  - ☐ Hunting ☐ Power tools ☐ Any job that is noisy
- ○ Yes ○ No 15. Were you in the military or National Guard?
- ○ Yes ○ No 16. Have you in your job or hobbies, been exposed to loud noise levels?
- ○ Yes ○ No 17. Do you have trouble understanding in crowds, in church or at meetings?
- ○ Yes ○ No 18. Do you have trouble understanding speech on the telephone?

General/Constitutional

- ○ Yes ○ No 1. Have you ever received radiation to the head or neck?
- ○ Yes ○ No 2. Do you have untreated diabetes?

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Dizziness Questionnaire

Patient Name _____ **Date** _____

1. **Describe your symptoms:** _____

_____

_____

2. **Onset of symptoms:** _____

_____

_____

3. **Onset nature:** ☐ Gradually ☐ Suddenly

4. **Severity of Symptoms:**
◯ More Frequently ◯ More Severe ◯ Improved ◯ No change ◯ Worse

5. **Select all that apply to your dizzy spells:**

- ☐ Preceded by flu/cold
- ☐ Spinning sensation
- ☐ Falling on Right side
- ☐ Fall on Left side
- ☐ Trouble walking in the dark
- ☐ No symptoms between attacks
- ☐ Nausea
- ☐ Vomiting
- ☐ Perspiration, shortness of breath, or feeling of panic
- ☐ Lightheadedness or swimming sensation
- ☐ Better if sit or lie still
- ☐ Fullness/pressure/ringing in the ears
- ☐ Stress
- ☐ Menstrual period
- ☐ Hormonal changes
- ☐ Overwork or exertion
- ☐ Headaches
- ☐ Loud noises
- ☐ Diet

6. **Imbalance when walking?** ◯ Yes ◯ No ◯ to the right ◯ to the left

7. **Comes in attacks or episodes?** ◯ Yes ◯ No

8. **How often?**
◯ Daily ◯ Multiple times a day ◯ Weekly ◯ Monthly ◯ Multiples times a year ◯ Annually

9. **How long do they last?** ◯ Seconds ◯ Minutes ◯ Hours ◯ Days

10. **When was the last attack or episode?** _____

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11. Dizziness/Imbalance worsens with:

- ☐ Standing
- ☐ Walking
- ☐ Walking in the dark
- ☐ Transferring to standing from sitting or supine
- ☐ position Pitching head up/down
- ☐ Yaw to left or right
- ☐ Lying supine in bed
- ☐ Changing positions in bed
- ☐ Stress/Fatigue
- ☐ Optokinetic hypersensitivity
- ☐ Any high gain acceleration in nonspecific directions

12. Other sensations include:

- ☐ Blacking out or fainting when dizzy
- ☐ Dizzy or unsteady constantly
- ☐ Severe or recurrent headaches
- ☐ Double or blurry vision
- ☐ Numbness in the face or extremities
- ☐ Weakness/Clumsiness in arms or legs
- ☐ Slurred or difficult speech
- ☐ Tingling around mouth
- ☐ Spots before eyes
- ☐ Jerking of arms or legs
- ☐ Dizzy when stand up quickly
- ☐ Weakness/Faintness after eating
- ☐ Difficulty Swallowing

13. My current symptoms also include:

- ☐ Difficulty hearing in Right ear
- ☐ Difficulty hearing in Left ear
- ☐ Ringing in Right ear
- ☐ Ringing in Left ear
- ☐ Fullness in Right ear
- ☐ Fullness in Left ear
- ☐ Pain in Right ear
- ☐ Pain in Left ear
- ☐ Discharge in Right ear
- ☐ Discharge in Left ear
- ☐ Hearing change in Right ear
- ☐ Hearing change in Left ear
- ☐ Exposure to loud noise in Right ear
- ☐ Exposure to loud noise in Left ear
- ☐ History of Right ear infection
- ☐ History of Left ear infection
- ☐ Change in hearing when dizzy

14. Have you ever had previous ear surgery?

◯ Yes ◯ No ◯ Years ago ◯ Months ago

15. Medical History also includes:

- ☐ Back or neck surgery
- ☐ Back or neck pain
- ☐ Seasickness or car sickness
- ☐ Motion intolerance
- ☐ Sensitivity to light and/or sound
- ☐ Not applicable

16. What physicians or specialists have you seen previously?

_____

17. What tests have been done previously for your dizziness?

☐ Audiogram ☐ MRI ☐ CTscan ☐ Bloodwork ☐ Angiogram ☐ Other: _____

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Dizziness Handicap Inventory

Name: _____ Date Completed _____

1	Does looking up increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
2	Because of your problem, do you feel frustrated? (E)	☐ Yes	☐ Sometimes	☐ No
3	Because of your problem, do you restrict your travel for business or recreation? (F)	☐ Yes	☐ Sometimes	☐ No
4	Does walking down the aisle of a supermarket increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
5	Because of your problem, do you have difficulty getting into or out of bed? (F)	☐ Yes	☐ Sometimes	☐ No
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? (F)	☐ Yes	☐ Sometimes	☐ No
7	Because of your problem, do you have difficulty reading? (F)	☐ Yes	☐ Sometimes	☐ No
8	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? (F)	☐ Yes	☐ Sometimes	☐ No
9	Because of your problem, are you afraid to leave your home without having someone accompany you? (E)	☐ Yes	☐ Sometimes	☐ No
10	Because of your problem, have you been embarrassed in front of others? (E)	☐ Yes	☐ Sometimes	☐ No
11	Do quick movements of your head increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No
12	Because of your problem, do you avoid heights? (F)	☐ Yes	☐ Sometimes	☐ No
13	Does turning over in bed increase your problem (P)	☐ Yes	☐ Sometimes	☐ No
14	Because of your problem, is it difficult for you to do strenuous household or yard work? (F)	☐ Yes	☐ Sometimes	☐ No
15	Because of your problem, are you afraid people may think you are intoxicated? (E)	☐ Yes	☐ Sometimes	☐ No
16	Because of your problem, is it difficult for you to walk by yourself? (F)	☐ Yes	☐ Sometimes	☐ No
17	Does walking down a sidewalk increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No

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18	Because of your problem, is it difficult for you to concentrate? (E)	☐ Yes	☐ Sometimes	☐ No
19	Because of your problem, is it difficult for you to walk around your house in the dark? (F)	☐ Yes	☐ Sometimes	☐ No
20	Because of your problem, are you afraid to stay home alone? (E)	☐ Yes	☐ Sometimes	☐ No
21	Because of your problem, do you feel handicapped? (E)	☐ Yes	☐ Sometimes	☐ No
22	Has your problem placed stress on your relationships with members of your family or friends? (E)	☐ Yes	☐ Sometimes	☐ No
23	Because of your problem, are you depressed? (E)	☐ Yes	☐ Sometimes	☐ No
24	Does your problem interfere with your job or household responsibilities? (F)	☐ Yes	☐ Sometimes	☐ No
25	Does bending over increase your problem? (P)	☐ Yes	☐ Sometimes	☐ No

---

This section will be completed by your clinician.

Scoring: Yes = 4 points; Sometimes = 2 points; No = 0 points

Functional Subscale	= F	_____ /	36
Emotional Subscale	= E	_____ /	40
Physical Subscale	= P	_____ /	24
Total Score		_____ /	100

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Fill this form out if you would like person(s) or organization(s) to receive information regarding your medical records such as Primary Care Physician, E.N.T., Neurologist, family member (spouse), caregiver, etc.

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize **Newport-Mesa Audiology Balance & Ear Institute** to release all health information about me.

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

☐ Send Records ☐ Do Not Send Records

Person/Organization to Receive Information	☐ Provider	☐ Family/Friend/Caretaker
Address (Street Address, City, State, Zip Code)		
Phone Number	Fax Number	

☐ Send Records ☐ Do Not Send Records

Person/Organization to Receive Information	☐ Provider	☐ Family/Friend/Caretaker
Address (Street Address, City, State, Zip Code)		
Phone Number	Fax Number	

☐ Send Records ☐ Do Not Send Records

Person/Organization to Receive Information	☐ Provider	☐ Family/Friend/Caretaker
Address (Street Address, City, State, Zip Code)		
Phone Number	Fax Number	

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The following health information that relates to service beginning from _____ to _____, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)
- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

☐ Change of Doctor
☐ Individual Request
☐ Specialist Referral
☐ Workers Compensation
☐ Insurance Purposes
☐ Continued Treatment
☐ Legal Investigation
☐ Other:_____

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand this authorization is voluntary. This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative	**Date Signed**	**Description of Personal Representative's Authority**

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NOTICE OF PRIVACY PRACTICES

NEWPORT-MESA AUDIOLOGY BALANCE & EAR INSTITUTE, INC.

Bee Yang - Privacy Officer

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF: **THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA); THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH); THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA); ALSO KNOWN AS THE FINAL HIPAA OMNIBUS RULE.** PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Alternatively, we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities, which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we cannot agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing.

We will charge a reasonable fee, which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

NEWPORT-MESA AUDIOLOGY
BALANCE & EAR INSTITUTE

500 Old Newport Boulevard
Suite 101
Newport Beach, CA 92663

949.642.7935 Phone
949.642.2950 Fax
dizziland.com

HIPAA & Notice of Privacy Practices Agreement

- I authorize release of any medical information necessary to process any and all medical claims.
- I authorize treatment and request treatment at Newport-Mesa Audiology Balance & Ear Institute.
- This authorization is effective for all health care information and I understand that I may ask for and receive a copy of this authorization form.
- I understand I have the right to inspect the information I am authorizing to be re- released. This and other specific rights regarding the handling of my health information is outlined in the Privacy Practices document.
- The information that I am authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- I understand and agree that I am ultimately responsible and liable for any amounts not paid by my insurance company.
- I authorize payment of all my medical benefits to Newport-Mesa Audiology Balance & Ear Institute, Inc.
- I hereby sign this in acknowledgement that I have been presented with a copy of the Notice of Privacy Practices.

Name of Patient: _____

Signature of Patient: _____

Date: _____

NEWPORT-MESA AUDIOLOGY
BALANCE & EAR INSTITUTE

500 Old Newport Boulevard
Suite 101
Newport Beach, CA 92663

949.642.7935 Phone
949.642.2950 Fax
dizziland.com

INSURANCE PAYMENT RIDER

This Insurance Payment Rider is entered into by and between Newport-Mesa Audiology, Inc., (hereinafter referred to as Facility) and you, the Patient (hereinafter referred to as Patient) or Patient's legal guardian with respect to the following:

BILLING/PAYMENT: Patient agrees that he/she is financially responsible for payment of all services rendered by Newport-Mesa Audiology. Patient understands that Facility will bill Patient's insurance carrier as a courtesy only, and there is no understanding that Newport-Mesa Audiology will agree to accept only what Patient's insurance company pays, as payment in full. Patient understands that, as a result of such billing, the Patient's insurance carrier may send payments directly to the Patient for services provided to the Patient. Should any action be taken to enforce this agreement the prevailing party shall be entitled to the reasonable attorney fees and costs incurred in enforcing this agreement. This Agreement shall be governed by and interpreted and construed in accordance with the laws of the State of California with venue expressly agreed to the Superior Court of the County of Orange.

1. I as the Patient agree to:
    a. Upon receipt of said insurance check, deposit said check;
    b. Within ten (10) days, remit payment directly to Newport-Mesa Audiology along with any and all Explanation of Benefits (EOB); and,
    c. Payments should be mailed to:

Newport-Mesa Audiology, Inc.
500 Old Newport Blvd., Suite 101
Newport Beach, CA 92663
Attention: Patient Accounts

2. ***CONSENT TO RELEASE INFORMATION:*** Patient expressly agrees that Newport-Mesa Audiology may:

    a. Bill Patient's insurance carrier for any and all services rendered, if applicable;
    b. Obtain any and all information from Patient's insurance carrier regarding such billing including, without limitation, whether Facility's bill has been accepted, whether payment has been made directly to the Patient, when payment occurred and the amount paid; and,
    c. Release any and all information as requested by Patient's insurance carrier in accordance with billing practices and procedures.

3. ***Treatment & Payment Agreement:***
    a. I authorize examination and treatment for this and all following provider visits.
    b. I authorize and release any medical information necessary to process insurance billings.
    c. I authorize payment and assignment of my insurance benefits to Newport-Mesa Audiology.
    d. I am personally responsible for supplying accurate and current insurance information.
    e. I understand that I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this agreement to serve as an original.

I,_____ , agree to the terms as set for the above. Dated:_____

_____ _____
Patient/Legal Guardian Signature Name Printed

_____ _____
Newport-Mesa Audiology Representative Signature Name Printed