Physical Therapy & Beyond
Michigan Ear Institute

30055 Northwestern Highway, Suite # 105,
Farmington Hills, MI 48334
Tel: 248-865-4148
Fax: 248-865-4129

Patient Information

Last Name: _____First Name: _____Middle Initial:_____

Email: _____

Address: _____ City:_____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security# _____

Home Phone #:_____Work Phone #:_____Cell #:_____

Marital Status: Single_____Married_____Divorced_____Widowed_____

Emergency Contact: _____Phone #_____Relationship_____

Primary Care Physician / Family Doctor(s)_____

Are you currently under the care of a Home Health Agency?____No____Yes, name of Co._____

How did you hear about us?_____

Insurance Information

Medicare #_____ Part B effective date_____

Insurance Policy #_____Group #:_____

Policyholder's Name: _____Relation to Patient:_____DOB:_____

Insurance Address (if other than above):_____

If Patient is a minor

Responsible party for bill if other than patient:_____Relationship:_____

Responsible party's address (if other than above):_____

Date of Birth:_____ Social Security #_____

Consent for Treatment:
I hereby consent to receive care for therapy services by Physical Therapy & Beyond at Michigan Ear Institute. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:
I authorize Physical Therapy & Beyond at Michigan Ear Institute to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:
I authorize Physical Therapy & Beyond at Michigan Ear Institute. to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, CT scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:
I hereby authorize payment to be made directly to Physical Therapy & Beyond at Michigan Ear Institute.

Guarantee of Payment:
I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature:_____Date:_____

Physical Therapy & Beyond
of MEI Michigan Ear Institute

RESET FORM

CLIENT HEALTH QUESTIONNAIRE

Name_____ Age_____ Date____/____/____

Describe Current Complaint? Limitation: _____

Describe how your problem began: _____

Please tell us how long ago your condition started: _____

List tests / interventions for this condition that you have had: _____

Daily activities that you cannot perform due to your condition:_____

Level of functioning prior to the onset of this condition: _____

Please inform us of any environmental or living conditions that may have difficulties with: _____

Recent surgery? ○ No ○ Yes Date____/____/_____ Procedure: _____

Please describe the nature of your symptoms (check **all** that apply):

☐ Vertigo / Spinning	☐ Headaches / Migraines	☐ Sharp Pain
☐ Lightheadedness	☐ Concussion / Head Injury	☐ Shooting Pain
☐ Imbalance	☐ Muscle Weakness _____	☐ Dull (Pain) Ache
☐ Feeling "Off"	☐ Numbness _____	☐ Throbbing Pain
☐ Positional _____	☐ Ear Pressure / Pain	☐ Burning
☐ Motion Intolerance	☐ Tinnitus / Ringing in Ear	☐ Tingling (Pins & Needles)_____
☐ Nausea	☐ Vision – Blurry / Double	☐

Are your symptoms Constant? ○ **YES** ○ **No**

If not constant please describe frequency & duration – (How many times per day/week/month for how long)

_____

Level of symptoms: From 0 -10 (No symptoms - Unbearable) _____at rest _____ with activity

Since this condition began your symptoms have: ○ decreased ○ not changed ○ increased

Your symptoms are worse in: ○ Morning ○ Later in day ○ Night ○ Same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Has your work status changed because of this condition ○ NO ○ YES _____

Medical History:

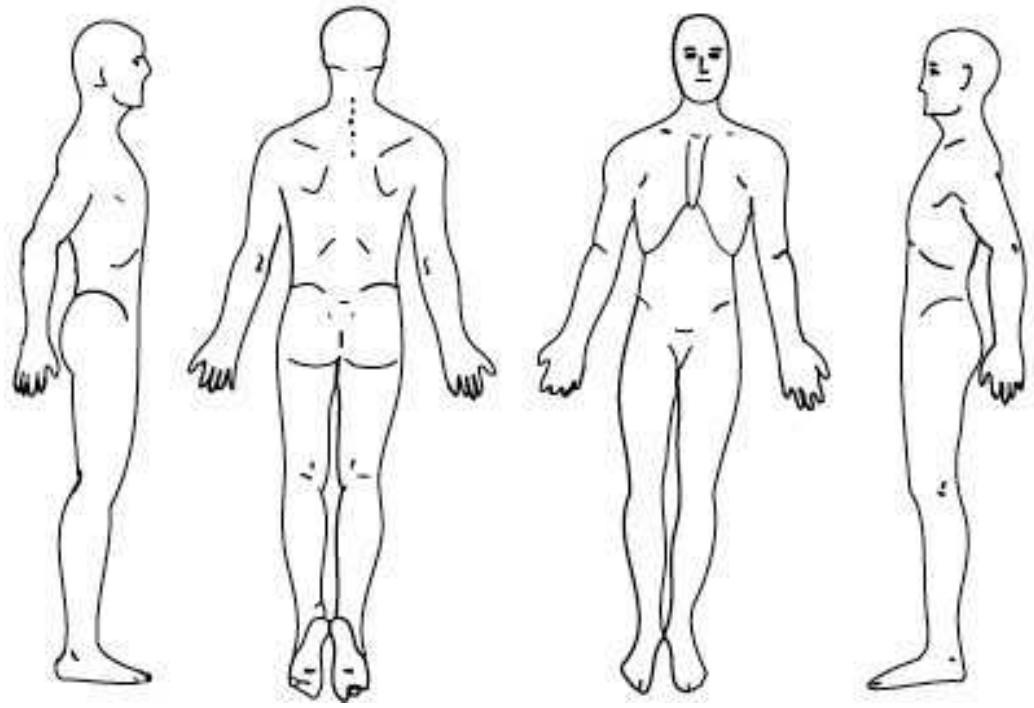
☐ High Blood Pressure	☐ Cancer / Tumour	☐ Allergies _____
☐ Angina / Irregular HR	☐ Systemic Lupus	☐ Tobacco – packs / day ____
☐ Heart Attack	☐ Hepatitis	☐ Drugs / Alcohol dependence
☐ Do you have a Pacemaker?	☐ Epilepsy / Seizures	☐ Rheumatoid Arthritis
☐ Stroke	☐ Diabetes	☐ Arthritis
☐ Any Joint replacements? _____	☐ HIV / AIDS	☐ Asthma
☐ Any metal Implants? _____	☐ Hepatitis	☐ Pregnancy
☐ Serious Injuries in past?		☐ Other -

Past Surgical / hospitalization History: _____

Have you fallen in the last year? ○ No ○ YES - If yes, how many times? _____

Were you hurt because of your fall? ○ No ○ YES (Describe) _____

Please Mark on the picture locations of pain if present



Additional Comments:

Physical Therapy & Beyond

MEI Michigan Ear Institute

Dizziness Handicap Inventory

Patient Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

RESET FORM

	Questions about DIZZINESS	Always	Sometimes	No
P1	Does looking up increase your problem?	○	○	○
E2	Because of your problem, do you feel frustrated?	○	○	○
F3	Because of your problem, do you restrict your travel for business or pleasure?	○	○	○
P4	Does walking down the aisle of a supermarket increase your problem?	○	○	○
F5	Because of your problem, do you have difficulty getting into or out of bed?	○	○	○
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	○	○	○
F7	Because of your problem, do you have difficulty reading?	○	○	○
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	○	○	○
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	○	○	○
E10	Because of your problem, have you been embarrassed in front of others?	○	○	○
P11	Do quick movements of your head increase your problem?	○	○	○
F12	Because of your problem, do you avoid heights?	○	○	○
P13	Does turning over in bed increase your problem?	○	○	○
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	○	○	○
E15	Because of your problem, are you afraid people may think that you are intoxicated?	○	○	○
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	○	○	○
P17	Does walking down a sidewalk increase your problem?	○	○	○
E18	Because of your problem, is it difficult for you to concentrate?	○	○	○
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	○	○	○
E20	Because of your problem, are you afraid to stay home alone?	○	○	○
E21	Because of your problem, do you feel handicapped?	○	○	○
E22	Has your problem placed stress on your relationship with members of your family or friends?	○	○	○
E23	Because of your problem, are you depressed?	○	○	○
F24	Does your problem interfere with your job or household responsibilities?	○	○	○
P25	Does bending over increase your problem?	○	○	○

FOR OFFICE USE ONLY: # YES ___X4=___ #SOMETIMES ___X2=___ TOTAL = ____

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Scoring for Dizziness Handicap Inventory

Evaluation Date	Total Functional	Total Emotional	Total Physical	TOTAL SCORE
	0	0	0	0

Always = 4

Sometimes = 2

No = 0

P = physical

E = emotional

F = functional

→ **Subscales**

Notes:

1. **Subjective measure of the patient's perception of handicap due to the dizziness**
2. **Top score is 100 (*Maximum perceived disability*)**
3. **Bottom score is 0 (*No perceived disability*)**
4. **The following 5 items can be useful in predicting BPPV**
   - *Does looking up increase your problem?*
   - *Because of your problem, do you have difficulty getting into or out of bed?*
   - *Do quick movements of your head increase your problem?*
   - *Does bending over increase your problem?*
5. **Can use subscale scores to track change as well**

Physical Therapy & Beyond at MEI Michigan Ear Institute

Please list all prescription medications, over the counter medications, herbal medications, vitamins and supplements that you are currently taking in the table below.
Bring this completed list with you to your appointment.

Name	Dosage	Frequency (i.e. daily, weekly, etc.)	Route (i.e. oral, eye drops, nasal spray, etc.)

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Cancellation & No-Show Policy

In order to ensure that you, the patient, get maximum benefit from your therapy program, it is essential that you attend ALL scheduled sessions and complete any home activities assigned by your therapist.

We strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. We value your time and we hope that you will also value the time of our therapists by calling our office if there is a reason that you are unable to keep your appointment. **248 – 865 – 4148.**

Please inform us of the reason for your cancellation so we can support you when rescheduling.

Late Cancellation – Less than 24 hours' notice. *No-Show – When you miss an appointment without informing us.*

If you fail to come to your appointments, the following cancellation policy is enforced:

- **First No-Show / Late Cancellation**: You will receive a phone call informing you that you missed the scheduled appointment.
- **2ND & 3rd No-Show / Late Cancellation**: You will receive notification (via email or phone call) that two (2) appointments have now been missed without notifying the office within the appropriate time frame and you will be charged a **$35.00 fee**.
- Another no-show may result in dismissal from the clinic.

THE PATIENT IS RESPONSIBLE FOR THIS FEE, NOT THE INSURANCE / THIRD PARTY PAYOR.

If you know you will be late for an appointment, please give us a call to be sure you can still be seen and to check if rescheduling is necessary.

Plan your drive in so you can arrive on time for your scheduled appointment.

We look forward to working with you and in helping meet your physical therapy goals.

Please sign below to indicate that you have read this policy carefully, understand it and will adhere to this policy.

Patient Signature: _____ Today's Date: _____

Patient Name (PRINTED): _____

Michigan Ear Institute, P.L.L.C.

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of Michigan Ear Institute, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment

for your care, such as family members or friends. We are not required to agree to your request; how ever, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Michigan Ear Institute, Medical Records, 248-865-4444.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michigan Ear Institute Medical Records, 248-865-4444. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice contact Michigan Ear Institute Medical Records, 248-865-4444.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michigan Ear Institute, Practice Administrator, 248-865-4444. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy practices, please contact our administrator or clinical manager at 248-865-4444.

I hereby acknowledge that I have presented with a copy of Michigan Ear Institutes' Notify of Privacy

PRINT NAME OF PATIENT: _____

PATIENT SIGNATURE: _____

DATE: _____

MEI PATIENT REPRESENTATIVE: _____