North Clinic (or) South Clinic

Balance Institute
of Indiana

Dedicated to the Evaluation, Treatment, and Research of Balance Impairments

APPOINTMENT SCHEDULED FOR: _____

*(PLEASE NOTE THERE IS A **$50** CANCELLATION/NO SHOW CHARGE IF NOTIFICATION IS LESS THAN 24 HOURS)*

PRIOR TO APPOINTMENT:

- **VERIFY YOUR BENEFITS WITH YOUR INSURANCE COMPANY**
- **THOROUGHLY** COMPLETE ALL PAPERWORK
- **DISCONTINUE ANY MEDICINES** YOU ARE TAKING **FOR DIZZINESS** 24 HOURS PRIOR TO APPOINTMENT.
- ***IF YOU ARE RECEIVING HOME HEALTH OR LONG TERM CARE SERVICES, YOUR PHYSCIAL THERAPY APPOINTMENT MAY NOT BE COVERED.*** *Please contact our office for details*

AT TIME OF ARRIVAL PLEASE PROVIDE THE FOLLOWING:

- **COMPLETED PAPERWORK** *(We reserve the right to reschedule if this is not completed)*
- **COMPREHENSIVE LIST** OF **ALL** MEDICATIONS **INCLUDING DOSAGES/FREQUENCY/ROUTE OF ADMINSTRATION** (Please include all over the counter, herbals, vitamins/minerals/supplements)
- INSURANCE CARDS
- PHOTO ID
- PRESCRIPTION/REFERRAL FORM FOR EVALUATION FROM YOUR REFERRING DOCTOR

Driving Directions:

NORTH CLINIC: located on the Northeast side of Indianapolis approximately 6 blocks south of Community North Hospital on North Shadeland Ave. From I-465 traveling either direction, Take exit 37B (I-69) North to exit (82nd and Castleton). Continue South on Shadeland Ave. The clinic is located on the right hand side of the southwest corner of 75th and Shadeland Ave. We are in a two-story grey brick building across from Chase Bank. (**Look for the Starbucks next door!**) ***7440 N Shadeland Ave, Suite 130 (Phone: 317-577-7333)***

SOUTH CLINIC: located on South East Street (US 31 South) between Edgewood Ave. and Banta Rd. in the **Jamestowne Executive Offices** (*sign also reads **Wessler Engineering***).

- FROM THE NORTH: take I-465 to South East St. toward Greenwood. Take a left **AFTER** Edgewood Ave into the office complex.
- FROM THE SOUTH: travel north on US31. After Banta Rd, take the 2nd entrance into the office complex. The clinic is located on the inside corner of the first building on the right.
  6249 S East Street, Suite C (Phone: 317-783-1295)

BALANCE INSTITUTE OF INDIANA
Phone (317)577-7333 Fax (317)577-7330

Confidential Medical History/Evaluation

Name: _____ **Age:** _____ **Today's Date:** ___/___/___ **Date of Birth :** ___/___/___

Occupation:_____ Is this injury? Work Related Auto Accident **Date of Injury:** _____

Describe injury: _____

Are you currently seeing a Physical Therapist? Y N **For what condition:** _____

Rate severity of symptoms today: (*rate 0-10*) **Dizziness:** ____/10 **Balance Deficit:** ____/10

What are your symptoms: _____ ***When did they begin:** _____

Condition: (*circle*) Acute - Chronic - Constant - Comes and Goes - Spells/Attack **Do you use:** CANE - WALKER - WHEELCHAIR

Current Symptoms: (*circle*) Aching - Burning - Cramping - Deep - Dull - Heavy - Numbness - Stabbing - Throbbing - Weakness

Lightheaded - Vomiting - Nausea - Unsteady walking/standing - Headaches - Woozy - Pressure - Spinning - Jumping vision

Rocking sensation - Sense of leaning/tilting - Frequent falling - Staggering - Disorientation - Blurry/Double Vision - False sense of self motion

False sense/visual surround is moving - Occurs after a change in head/body position - Triggered by complex or large moving visual stimulus

Ears: ringing popping fullness pain **Hearing loss:** R L *** **Pain:** Jaw Neck Back ***RATE Pain: ____/10

How long do symptoms last? SECONDS MINUTES HOURS DAYS **How frequent do the symptoms occur?** _____

***When was your last spell?** _____

***How many times have you fallen in the past 6-12 months?** _____ ***What Injuries occurred?** _____

***When was your last fall?** _____ ***Describe your last fall:** _____

Any Diagnostic Testing for this Injury? MRI MRA X-rays CT scan EKG EMG VNG Audiogram Blood work Rotary chair VEMP

Other: _____

Circumstances that may cause/increase symptoms? (*circle all that apply*)

Reaching Back
Lying Flat
Getting up out of bed
Dressing & Grooming
Cooking/Home Chores
Carrying items
Climbing stairs
Sitting
Twisting
Lifting Anything
Lifting Heavy Weights
Pulling
Raising arm over the head
Looking up/down
Walking
Bending
Sudden Movement
Looking out window of car
Sit to Stand
Concentration
Turning Head R or L
Prolonged Sitting
Reading
Stress/fatigue
Passing traffic/trains
Blowing nose
Coughing/straining
Bending/leaning down
Rolling over in bed
Prolonged Standing
Walking in the dark
Loud noises
Yard Work
Menstrual cycle
Bright lights
Grocery/mall aisle
Physical exertion
Driving/riding in car
TV/Computer

What relieves your vertigo/balance pain? (*circle all that apply*)

Ice
Pain Medication
Heat
Lying Flat
Stretching
Avoiding activity
Exercise
Nothing

Medical History: (circle all that apply)

Allergies
Angina
Blood Clot/Emboli
Cellulitis
Coronary Heart
Emphysema
Gout
Heart Attack
Intractable Pain
Low Blood Sugar
Osteoarthritis
Parkinson's Disease
Sciatica
Spinal Stenosis
Torticollis
Vision Difficulties
Allergic to Latex
Asthma
Bowel/Bladder
Cerebral Palsy
Depression
Energy Loss
Guillain-Barre Syndrome
Heart Disease
Kidney Disease
Lumpectomy
Osteoporosis
Pneumonia
Shortness of Breath
Stroke/TIA
Varicose Veins
Weakness
Amputation
Ataxia
Bronchitis
Concussion
Dizziness/Faintness
Epilepsy/Seizures
Headache, Severe
Hernia
Lipedema
Lupus
Oxygen Dependency
Pregnancy, Current
Sleep Apnea
Thyroid
Vasculitis
Weight Loss
Anemia
Bell's Palsy
Carpal Tunnel
COPD
Drink Alcohol
Epstein-Barr
Hearing Difficulty
High BP
Low BP
Lyme Disease
Pacemaker
Rheum. Arthritis
Sleeping Problem
*Tobacco Use
Vertigo/Balance
Women's Health Issues
Arthritis (where?) _____
Numbness/Neuropathy (where?)_____
Joint replacement (where?)_____
Cancer (Type) _____
Anxiety
Concussion
Diabetes (1 or 2)
Falling
Head Injury
Infectious Disease
Back Pain (low/upper)
Memory Loss
Motion Sickness
MS
Panic Attack
Punctured Ear Drum

WHAT ARE YOU UNABLE TO DO BECAUSE OF YOUR BALANCE ISSUES? _____

_____

_____

Caffeine Use Per Day: _____ Chocolate Per Day: _____
*Smoking: Daily (#) _____ Weekly (#) _____
Exercise: Daily (#) _____ Weekly (#) _____
Alcohol Consumption: Daily (#) _____ Weekly (#) _____

Do you live alone: Yes or No
Does your home have stairs: Yes or No
Where do you live? Home - Apartment - Assisted Living Facility

BALANCE INSTITUTE OF INDIANA

Phone: (317) 577-7333 Fax: (317) 577-7330

Patient Name: _____ SSN# _____ DOB: _____

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

Home Phone: ( )_____ Cell Phone: ( ) _____

Work Phone: ( ) _____ _____ **E- MAIL :** _____

Primary Insurance Policy Holder's Name: _____ DOB: _____ SSN# (if not the patient): _____

Emergency Contact: _____ **Phone Number:** _____

RELEASE OF MEDICAL INFORMATION: _____ **initials**

I authorize Balance Institute of Indiana to release medical records concerning myself/son/daughter/other dependent to any physician, hospital, individual or agency involved in the care of the patient listed below. Please release my records to the ***NON-REFERRING*** practitioner or other listed below. (This request will expire in 6 months from date of signature.)

Physician/Other: _____ ____ **Please send this doctor a copy of my notes**

Address: _____

Phone/Fax: _____

ASSIGNMENT OF BENEFITS: _____ **initials**

I authorize my insurance carrier to assign medical benefits to Balance Institute of Indiana. I also authorize release of medical information necessary to process all medical insurance claims. **I understand I am responsible to inform the Balance Institute of Indiana office of any changes that occur, including but not limited to, change in insurance carrier.**

PAYMENT POLICY: _____ **initials**

Co-payments are due at the time services are received. We accept cash, check, and credit cards. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept its negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office **PRIOR** to services. A ***$5.00 fee*** will be due on your initial visit for education supplies you may receive. **Should I, the patient, default on my financial responsibility and collection action is necessary, I will be responsible for the collection costs, including attorney fees that are incurred. I am aware a *$35.00 fee* will be assessed to all checks submitted with non-sufficient funds.**

CANCELLATION/NO SHOW POLICY: _____ **initials**

Our office requires **a 24 hour notice of cancellation.** We have 24 hour voice mail to assist with this. Cancellations and no show fees are the patient's responsibility and will NOT be billed to your insurance. Fee payments are due on or before your NEXT appointment. **I, the patient, agree to pay a *$50.00 fee* for each late cancellation or no show appointment.**

BII MEDICAL WELLNESS RECOMMENDATIONS: _____ **initials**

I am aware and have received the BII Wellness Recommendations with my New Patient Paperwork

HIPAA: _____ **initials**

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES, AND CLINIC POLICIES:

X: _____ X: _____

Signature of Responsible Party **Date, Read and Signed**

Does your diagnosis impact your ability to attend work/school? ***(check all that apply)***

- ○ I am retired
- ○ The diagnosis prevents me from working or attending school
- ○ I can only work part time
- ○ My diagnosis is a big impact on my work/school
- ○ I can work or attend school with great difficulty
- ○ I can work or attend school with minor impact.
- ○ I am unable to participate in any sporting events
- ○ The diagnosis does *not* impact my ability to work or attend school
- ○ Not applicable

ANSWER AS IT RELATES TO YOUR CONFIDENCE WITH YOUR BALANCE AS OF TODAY - with ZERO being you will fall and 100% being completely safe that you will not lose your balance or become unsteady.

WILL FALL 0% 10 20 30 40 50 60 70 80 90 100% ***SAFE***

Walking around the house? _____%
Walking up or down stairs? _____%
Bending over and picking up a slipper from the front of the closest/floor? _____%
Reaching for a small can on a shelf at eye level? _____%
Standing on your tip toes and reaching for something above your head? _____%
Standing on a chair and reaching for something? _____%
Sweeping the floor? _____%
Walking outside of the house to a car parked in the driveway? _____%
Getting into and out of a car? _____%
Walking across a parking lot to the mall? _____%
Walking up or down a ramp? _____%
Walking in a crowded mall where people rapidly walk past you? _____%
When bumped into by people as you are walking through the mall? _____%
Stepping onto or off an escalator while you are holding onto a railing? _____%
Step onto or off an escalator holding onto parcels such that you cannot hold onto railing? _____%
Walking outside on icy sidewalks? _____%

MEDICATION/SUPPLEMENT LIST

(circle what applies)

PRESCRIPTIONS	DOSAGE	FREQUENCY	Route of Administration
			Oral – Sublingual – Topical - Injection
			Oral – Sublingual – Topical - Injection
			Oral – Sublingual – Topical - Injection
			Oral – Sublingual – Topical - Injection
			Oral – Sublingual – Topical - Injection
			Oral – Sublingual – Topical - Injection

Patient's Name: _____ **Date of Birth:** _____ **Todays Date:** _____

HEIGHT:_____ ***WEIGHT:***_____ ***SHOE SIZE:*** _____

THE BALANCE INSTITUTE OF INDIANA

Dizziness Handicap Inventory

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

	Questions	Yes (4)	Sometimes (2)	No (0)
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, 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 yardwork?			
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?			

Patient's Name: _____ **Date of Birth:** _____ **Today's Date:** _____

EVAL – INT – D/C

Telehealth Visit Permission to Treat

I, _____ (Print name), consent to participating in a telehealth visit with a Physical Therapist, who is an employee of Balance Institute of Indiana. I understand that the evaluation and treatment of current medical condition(s) using a synchronous video and/or audio call is under the Physical Therapy scope of practice similar to a clinic visit and will be carried out by a licensed practitioner.

I understand that the telehealth session will use Zoom, a computer application that allows for encrypted video meetings. Encrypted meetings are private meetings between the Physical Therapist and the patient that keeps health information on a secure line, prevents hacking, and reduces invasion of privacy. I understand that the version of Zoom used for telehealth visits does not have a business contact to be HIPAA compliant, however, Zoom does follow HIPAA guidelines to ensure private health information is kept secure throughout the session. This private health information is not stored after completion. No recording of the session will be done unless verbal consent is given.

I understand the Physical Therapist will conduct the session in a space that is conducive for keeping health information private and maintain professional guidelines. I understand that no physical exam or manual therapy will be given during a telehealth visit and I agree to the Therapist's plan of care that may be modified for telehealth.

I have also signed the general consent form for treatment from the clinic, Balance Institute of Indiana. The current clinic policies apply to telehealth visits as well.

I understand that this telehealth visit will not be billed to my insurance and therefore must be paid in full before the start of care. All Medicare patients will also complete the attached Advance Beneficiary Notice of Noncoverage (ABN) in compliance with regulations. The Physical Therapist has the right to refuse treatment if payment is not received.

_____ _____

Signature Date

_____ _____

Witness Date

Balance Institute
of Indiana

Dedicated to the Evaluation, Treatment, and Research of Balance Impairments

CREDIT CARD AUTHORIZATION

Please complete the form as completely as possible. This authorization can be withdrawn at any time.

Credit Card Information

Credit Card Company:

☐ Mastercard

☐ Visa

☐ Discover

Cardholder's Name (as written on the card): _____

Card Number: _____

Expire Date: _____

Billing Information:

Address: _____

City: _____

State: _____

ZIP Code: _____

Phone: _____

By Signing this form:

1) I authorize **Balance Institute of Indiana** to charge this card. I may choose to use other forms of payment such as cash or check. I understand that should my account be 30 days overdue; I authorize **Balance Institute of Indiana** to automatically charge this card.

2) I hereby grant permission to charge by credit card if there is an outstanding balance on my account without further authorization.

Authorized Signature: _____ Date: _____

7440 N. Shadeland Avenue, Suite 130 • Indianapolis, IN 46250 | **PHONE:** (317) 577-7333 **FAX:** (317) 577-7330
6249 South East Street, Suite C • Indianapolis, IN 46227 | **PHONE:** (317) 783-1295 **FAX:** (317) 783-0633