HEARING DOCTORS
OF NEW JERSEY

Patient Registration Form

☐ New patient registration
☐ Update of current patient demographic information

Demographic Information

Patient Name: _____ Date of Birth: _____

Date of Completion: _____ Preferred Name: _____

Birth Gender *(check one)*: ☐ Male ☐ Female

Gender *(check one)*: ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Non-Binary

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Primary Contact *(check one)*: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Appointment Reminders *(check all that apply)*: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

If child, please list the name of the custodial parents/guardians: _____

_____

Marital Status *(check one)*: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Name of Spouse/Partner, if applicable: _____

Current Employment Status *(check one)*:

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Stay at Home Parent ☐ Student

Current Employer: _____

Occupation: _____

Highest Level of Education Completed: _____

Social Security Number: _____

Spoken Language *(complete all that apply)*: ☐ English ☐ Spanish ☐ Other: _____

Race *(check one)*: ☐ American-Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other: _____

Ethnicity *(check one, if applicable)*: ☐ Hispanic ☐ Latino

Emergency Contact Information

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Physician Information

Referring Physician Name: _____ Phone: _____
Primary Care Physician Name: _____ Phone: _____

Would you like Hearing Doctors of NJ to send a copy of your current and future test results and/or reports to
(please check all that apply; by checking the box and listing names below, you are authorizing Hearing Doctors of NJ to communicate with these entities regarding your healthcare and treatment):

☐ Referring Physician: _____
☐ Primary Care Physician (PCP): _____
☐ Other Physician, please specify: _____
☐ School, please specify: _____
☐ Family Member(s)/Guardian(s), please specify: _____
☐ Other: _____
☐ None (self-pay option only)

How did you hear about Hearing Doctors of NJ? *(Please check all that apply)*:

☐ Hearing Doctors of NJ Facebook Page
☐ Hearing Doctors of NJ Website
☐ Hearing Doctors of NJ Sign
☐ Health Fair Event
☐ Open House
☐ Internet/Search Engine, please specify which one:
_____
☐ Family Member/Friend, please provide full name so Hearing Doctors of NJ may thank him/her for the referral: _____
☐ Doctor, please specify:
_____
☐ Phone book, please specify which one:
_____
☐ Direct Mail Piece, please specify which one:
_____
☐ Newspaper, please specify which one:
_____
☐ Other:
_____

Signature Information

_____ *(initial here)* By initialing this section and signing below, I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. The Notice provides information about how Hearing Doctors of NJ may use and disclose the medical information that is maintained about you. Hearing Doctors of NJ encourages you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

_____ *(initial here)* By initialing this section and signing below, I authorize Hearing Doctors of NJ to send me educational and/or marketing information on the products and services offered by Hearing Doctors of NJ. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ *(initial here)* By initialing this section and signing below, I agree to accept the financial policies of Hearing Doctors of NJ. I understand that payment in-full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of patient or custodial parent/guardian	Date
Printed name of patient or custodial parent/guardian	Date

HEARING DOCTORS
OF NEW JERSEY

Office and Financial Policies

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Thank you for choosing Hearing Doctors of NJ for your hearing and balance healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Hearing Doctors of NJ is only an in network provider with Horizon NJ Health. We are an out of network provider with all other insurance plans.

Insurance coverage is an agreement between you and your insurance carrier. It is your responsibility to determine whether or not you have out-of-network benefits, if you require prior authorization or a referral prior to services being provided, or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Hearing Doctors of NJ cannot submit a claim to any insurance carrier we are out of network with. Upon payment in full for services rendered, you will receive a paid in full invoice that you can submit to your insurance carrier for reimbursement.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Hearing Doctors of NJ reserves the right to charge a $50 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you, if time allows. Otherwise, we will need for you come back later in the day, if a later appointment is available, or reschedule to another date and time.

Payment in-full is due at the time the services are provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply.

Hearing Doctors of NJ accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover credit card. We also offers a third-party credit program through CareCredit and Healthi Plan. There will be a $50 fee for all bounced or returned checks.

It is also the policy of Hearing Doctors of NJ that we may maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 90 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment, if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Hearing Doctors of NJ reserves the right, following 90 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

I understand if I have an unpaid balance to Hearing Doctors of NJ and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Hearing Doctors of NJ or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Hearing Doctors of NJ and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____ _____

Signature of patient or personal representative Date

HEARING DOCTORS OF NEW JERSEY

Notice of Privacy Practices

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

ABOUT THIS NOTICE

Hearing Doctors of NJ is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how Hearing Doctors of NJ may use and disclose your protected health information to carry out treatment, payment or audiologic/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and Hearing Doctors of NJ's duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health/condition and related audiologic/health care services. Hearing Doctors of NJ must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

HOW HEARING DOCTORS OF NJ MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that Hearing Doctors of NJ may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

Treatment

Hearing Doctors of NJ may use and disclose your protected health information to provide, coordinate, or manage your audiologic treatment and any related services. Hearing Doctors of NJ may also disclose your protected health information to other third party providers involved in your audiologic/health care. For example, your protected health information may be provided to a physician or other audiologic/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiologic/health care provider has the necessary information to diagnose or treat you.

Payment

Hearing Doctors of NJ may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payers. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiologic/health care services Hearing Doctors of NJ recommends for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, Hearing Doctors of NJ may provide your health plan with medical information about the audiologic/health care services Hearing Doctors of NJ rendered to you for reimbursement purposes.

Audiological/Health Care Operations

Hearing Doctors of NJ may use and disclose your protected health information for audiologic/health care operation purposes. These uses and disclosures are necessary to make sure that all patients receive quality care and for operation and management purposes. For example, Hearing Doctors of NJ may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of Hearing Doctors of NJ's team members in caring for you. Hearing Doctors of NJ also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

Treatment Communications

Hearing Doctors of NJ may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which Hearing Doctors of NJ or a business associate may receive financial remuneration in exchange for making the communication, Hearing Doctors of NJ must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

Fundraising Activities

Hearing Doctors of NJ may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Hearing Doctors of NJ. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039.

Others Involved in Your Healthcare

Unless you object, Hearing Doctors of NJ may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Hearing Doctors of NJ may disclose such information, as necessary, if Hearing Doctors of NJ determines that it is in your best interest based on professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, Hearing Doctors of NJ may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. Hearing Doctors of NJ may also use and disclose protected health information to notify such persons of your location, general condition, or death. Hearing Doctors of NJ also may coordinate with disaster relief agencies to make this type of notification. Hearing Doctors of NJ also may use professional judgment and experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

Required by Law

Hearing Doctors of NJ may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health

Hearing Doctors of NJ may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Hearing Doctors of NJ may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
Hearing Doctors of NJ may disclose your protected health information to business associates that perform functions on Hearing Doctors of NJ's behalf or provide Hearing Doctors of NJ with services if the information is necessary for such functions or services. To protect your health information, however, Hearing Doctors of NJ require the business associate to appropriately safeguard your information.

Communicable Diseases
Hearing Doctors of NJ may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
Hearing Doctors of NJ may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the audiologic/health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
Hearing Doctors of NJ may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, Hearing Doctors of NJ may disclose your protected health information if Hearing Doctors of NJ believes that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
Hearing Doctors of NJ may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
Hearing Doctors of NJ may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement
Hearing Doctors of NJ may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation
Hearing Doctors of NJ may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. Hearing Doctors of NJ may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. Hearing Doctors of NJ may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
Hearing Doctors of NJ may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Serious Threat to Health or Safety

Consistent with applicable federal and state laws, Hearing Doctors of NJ may disclose your protected health information to prevent or lessen a serious threat to your health and safety, or to the health and safety of another person or the public.

Military Activity and National Security

If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, Hearing Doctors of NJ may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

Workers' Compensation

Hearing Doctors of NJ may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

For Data Breach Notification Purposes

Hearing Doctors of NJ may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Required Uses and Disclosures

Under the law, Hearing Doctors of NJ must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

The following uses and disclosures will be made only with your written authorization:

- Uses and disclosures of protected health information for marketing purposes for which Hearing Doctors of NJ or a business associate may receive remuneration; and
- Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Hearing Doctors of NJ has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to be Notified if there is a Breach of Your Protected Health information

You have the right to be notified upon a breach of any of your unsecured protected health information.

Right to Inspect and Copy
You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, NJ 07039. If you request a copy of your information, Hearing Doctors of NJ may charge you a reasonable fee for the costs of copying, mailing or other costs incurred in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, Hearing Doctors of NJ may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our privacy policy specialist at our office by calling (973)-577-4100 if you have questions about access to your medical record.

Right to Request Restrictions
You may ask Hearing Doctors of NJ not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039. Your request must state the specific restriction requested and to whom you want the restriction to apply. Hearing Doctors of NJ is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiologic/health care operation purposes and such information you wish to restrict pertains solely to an audiologic/health care item or service for which you have paid Hearing Doctors of NJ “out-of-pocket” in-full. If Hearing Doctors of NJ believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If Hearing Doctors of NJ does agree to the requested restriction, Hearing Doctors of NJ may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

Right to Request Confidential Communication
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Hearing Doctors of NJ will accommodate reasonable requests. You must request this by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039.

Right to Request Amendment
You may request an amendment of your protected health information contained in your medical and billing records and any other records that Hearing Doctors of NJ uses for making decisions about you, for as long as Hearing Doctors of NJ maintains the protected health information. You must request for an amendment by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request. In certain cases, Hearing Doctors of NJ may deny your request for an amendment. If Hearing Doctors of NJ denies your request for an amendment, you have the right to file a statement of disagreement with Hearing Doctors of NJ and they may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures
You have the right to receive an accounting of certain disclosures Hearing Doctors of NJ has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. It excludes disclosures Hearing Doctors of NJ may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to Hearing Doctors of NJ 340 E Northfield Rd #2B, Livingston, New Jersey 07039, and provide the reason(s) that support your request.

Right to Obtain a Paper Copy of this Notice
You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask Hearing Doctors of NJ to give you a copy of this notice at any time. To obtain a paper copy of this Notice, please contact our privacy policy specialist at our office by calling (973)-577-4100.

COMPLAINTS OR QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with Hearing Doctors of NJ or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with Hearing Doctors of NJ, Please contact our privacy policy specialist at our office by calling (973)-577-4100. All complaints must be submitted in writing. Hearing Doctors of NJ will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

Hearing Doctors of NJ reserves the right to change this Notice at any time. The new Notice will be effective for all health information Hearing Doctors of NJ already has about you as well as any information received in the future. You can also obtain a revised Notice at www.hearingdoctorsnj.com or by contacting Hearing Doctors of NJ at (973)-577-4100.

Hearing Doctors of NJ
340 E Northfield Rd #2B,
Livingston, New Jersey 07039

This Notice is effective as of April, 2020.

HEARING DOCTORS
OF NEW JERSEY

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

I acknowledge that I received a copy of Hearing Doctors of NJ's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on the website, and that I will be given a copy of any amended Notice of Privacy Practices upon request.

- This Notice informs me how Hearing Doctors of NJ will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Hearing Doctors of NJ may use and share my health information for other than treatment, payment, and health care operations.
- Hearing Doctors of NJ will also use and share my health information as required/permitted by law.

_____ _____

Signature of patient or personal representative Date

HEARING DOCTORS OF NEW JERSEY

Adult Case History Form

Patient Name: _____ Date of Birth: _____

Date: _____ Phone Number: _____

Address: _____

Gender: *(check one)* ◯ Male ◯ Female ◯ Transgender Male-to-Female ◯ Transgender Female-to-Male ◯ Non-Binary

Audiologic History

Do you experience hearing loss: *(check one)* ☐ Yes ☐ No

If so, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it *(check one)*: ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the hearing loss? _____

What do you think is the cause of the hearing loss? _____

Have you ever had a hearing test: *(check one)* ☐ Yes ☐ No

If so, when: _____

Are you experiencing or concerned about memory loss or cognitive health? *(check one)* ☐ Yes ☐ No

Did you know that improved hearing may positively impact memory and brain health? *(check one)* ☐ Yes ☐ No

PLEASE CHECK ALL OF THE MEDICAL CONDITIONS THAT APPLY:

☐ **Ear pain** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Ear drainage** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

Frequency of episodes: _____ Drainage Color: _____ Texture: _____ Odor: _____

☐ **Tinnitus/ringing/noises in ears** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

If so, when did it begin: _____

If so, frequency: _____

☐ **Dizziness, unsteadiness, vertigo, imbalance**

Do you feel dizzy today: *(check one)* ☐ Yes ☐ No

Is the dizziness accompanied by: *(check all that apply)*

☐ Hearing Loss ☐ Vomiting ☐ Nausea ☐ Ear Noises/Tinnitus ☐ Visual Changes

Does the dizziness feel like: *(check the best choice)*

☐ Lightheadedness ☐ Fainting/near fainting ☐ Imbalance ☐ Spinning sensation/Vertigo

When did the dizziness begin: _____

How often does it occur: _____

Have you fallen in the last 12 months: *(check one)* ☐ Yes ☐ No

If yes, have you been injured: *(check one)* ☐ Yes ☐ No **If yes**, please describe: _____

Does the tinnitus prevent you from falling asleep: *(check one)* ☐ Yes ☐ No
Does the tinnitus wake you up at night: *(check one)* ☐ Yes ☐ No

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Excruciating

Using the above scale, indicate the loudness of your tinnitus:
_____ Right now _____ On average _____ At its worst _____ At its least

Does the loudness of your tinnitus: *(check one)* ☐ stay constant day to day ☐ fluctuate greatly day to day
☐ occasionally decreases significantly ☐ occasionally increases significantly

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Low-Pitch				Mid-Pitch				High-Pitch		

Using the above scale, what is the pitch of your tinnitus? *(check the best number)*

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Not bothered		Mildly		Moderately			Severely			Extremely

Using the above scale, are you currently bothered by your tinnitus: *(check the best number)*

What have you tried to suppress the tinnitus: *(check all that apply)*
☐ Acupuncture ☐ Diet Change(s) ☐ Hearing Aid(s)
☐ Biofeedback ☐ Earplug(s) ☐ Sound therapy/Hearing masker(s)
☐ Cochlear Implant(s) ☐ Exercise ☐ TMJ Treatment
☐ Transcranial Magnetic Stimulation
☐ Cognitive Behavioral and Mindfulness Based Stress Reduction
☐ Surgery- explain: _____
☐ Drug Therapy- List: _____

Which options helped suppress the tinnitus: *(check all that apply)*
☐ Acupuncture ☐ Diet Change(s) ☐ Hearing Aid(s)
☐ Biofeedback ☐ Earplug(s) ☐ Sound therapy/Hearing masker(s)
☐ Cochlear Implant(s) ☐ Exercise ☐ TMJ Treatment
☐ Transcranial Magnetic Stimulation
☐ Cognitive Behavioral and Mindfulness Based Stress Reduction
☐ Surgery- explain: _____
☐ Drug Therapy- List: _____

Which options made the tinnitus worse: *(check all that apply)*
☐ Acupuncture ☐ Diet Change(s) ☐ Hearing Aid(s)
☐ Biofeedback ☐ Earplug(s) ☐ Sound therapy/Hearing masker(s)
☐ Cochlear Implant(s) ☐ Exercise ☐ TMJ Treatment
☐ Transcranial Magnetic Stimulation
☐ Cognitive Behavioral and Mindfulness Based Stress Reduction
☐ Surgery- explain: _____
☐ Drug Therapy- List: _____

Does head/neck movement change the tinnitus: *(check one)* ☐ Yes ☐ No

If so, does movement make the tinnitus: *(check one)* ☐ Less noticeable ☐ More noticeable

Have you seen another healthcare professional for the tinnitus: *(check one)* ☐ Yes ☐ No

If so, who and when: *(check all that apply)*

☐ Primary Care Physician: _____

☐ Naturopathic Physician: _____

☐ Ear, Nose, and Throat (ENT) Physician: _____

☐ Neurologist: _____

☐ Audiologist: _____

☐ Other: _____

Do you feel emotional or physical stress when the tinnitus is present: *(check one)* ☐ Yes ☐ No

If so, when is it worse: _____

Have you discussed the tinnitus with family, friends, and/or doctors/professionals: *(check one)* ☐ Yes ☐ No

If so, what was his/her/their response: _____

Are you currently pursing any form of compensation, sickness benefit, motor vehicle claim, or any other legal action related to your tinnitus: *(check one)* ☐ Yes ☐ No

If so, Medical contact: _____

Legal contact: _____

Initial Tinnitus

When did your tinnitus first begin: _____

Did the tinnitus begin: *(check one)* ☐ Gradually ☐ Suddenly

Has the tinnitus been present constantly since this date: *(check one)* ☐ Yes ☐ No

If no, when was the break: _____

Were there any accidents/life changes/medication changes/etc. immediately prior to the onset of the tinnitus: *(check one)* ☐ Yes ☐ No

If so, which event: *(check one)*

☐ Noise Exposure
☐ Head/neck trauma
☐ Motor Vehicle Accident
☐ Change in hearing
☐ Stress
☐ Change in health/disease
☐ Change in Medication
☐ Other: _____

Audiologic History

Are you sensitive to loud noise(s): *(check one)* ☐ Yes ☐ No

If so, what noise(s): _____

When did the sensitivity begin: _____

What happened before the sensitivity began: _____

Do you experience hearing loss: *(check one)* ☐ Yes ☐ No

If so, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it *(check one)*: ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice the hearing loss? _____

What do you think is the cause of the hearing loss? _____

Have you ever had a hearing test: *(check one)* ☐ Yes ☐ No

If so, when: _____

Which ear do you typically use to talk on the telephone: *(check one)* ☐ Right ☐ Left

PLEASE CHECK ALL OF THE MEDICAL CONDITIONS THAT APPLY:

☐ **Ear pain** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Ear drainage** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
Frequency of episodes: _____ Drainage Color: _____ Texture: _____ Odor: _____

☐ **Dizziness, unsteadiness, vertigo, imbalance**

Do you feel dizzy today: *(check one)* ☐ Yes ☐ No
Is the dizziness accompanied by: *(check all that apply)*
☐ Hearing Loss ☐ Vomiting ☐ Nausea ☐ Ear Noises/Tinnitus ☐ Visual Changes
Does the dizziness feel like: *(check the best choice)*
☐ Lightheadedness ☐ Fainting/near fainting ☐ Imbalance ☐ Spinning sensation/Vertigo
When did the dizziness begin: _____
How often does it occur: _____
Have you fallen in the last 12 months: *(check one)* ☐ Yes ☐ No
If yes, have you been injured: *(check one)* ☐ Yes ☐ No **If yes**, please describe:

☐ **Ear malformations** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **History of ear infections** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Previous ear surgery** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both
If so, when: _____

☐ **Sinus/allergy problems** _____

☐ **History of earwax buildup** If checked, which ear: *(check one)* ☐ Right ☐ Left ☐ Both

☐ **Family history of hearing loss** If checked, who is the family member: _____

☐ **Exposure to loud noise** If so, when: _____ What type of noise: *(check all that apply)*
☐ Military ☐ Recreational ☐ Employment ☐ Other: _____
Do/Did you wear hearing protection devices: *(check one)* ☐ Always ☐ Sometimes ☐ Never

☐ **Developmental disorder/delay.** Please explain: _____

☐ **Other** *(please describe)*: _____

Have you ever worn or tried a hearing aid or amplifier: *(check one)* ☐ Right ☐ Left ☐ Both

If so, when: _____

What type and/or style of hearing aid or amplifier: _____
Please describe your experience: _____

Do you consider yourself to be a tense/stressed person: *(check one)* ☐ Yes ☐ No

What do you do to relax: *(check all that apply)*

☐ Exercise ☐ Massage ☐ Yoga
☐ Listen to music ☐ Meditation ☐ Other: _____

Do you suffer from headaches/migraines: *(check one)* ☐ Yes ☐ No

If so, frequency: _____

Treatment(s): _____

Rank the following in order of your preferred treatment: *(1-first, 3-last)*

_____ Hearing Loss _____ Noise Sensitivity _____ Tinnitus

Medical History

Current Medications, Supplements, Vitamins- Prescription or Over-the-Counter:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

**continue on a separate page, if needed*

Do you currently take a Vitamin D supplement: *(check one)* ☐ Yes ☐ No

Allergies (foods, medications, plastics, latex, etc.): _____

Please circle all medical symptoms or conditions that apply:

Skin problems *(such as cancer, excessive bruising)* ☐ Yes ☐ No
Head problems *(such as brain injury, cognitive decline)*: ☐ Yes ☐ No
Eye problems *(such as blurred or double vision, visual loss)*: ☐ Yes ☐ No
Nose and sinus problems *(such as nose bleeds, sinus surgeries)*: ☐ Yes ☐ No
Mouth or neck problems *(such as trouble swallowing, dental issues)*: ☐ Yes ☐ No
Cardiovascular issues *(such as hypertension, chest pain, swelling, palpitations)*: ☐ Yes ☐ No
Respiratory issues *(such as shortness of breath, cough, wheezing)*: ☐ Yes ☐ No
Gastrointestinal issues *(such as nausea, vomiting, weight changes, diarrhea, pain)*: ☐ Yes ☐ No
Musculoskeletal issues *(such as joint pain, swelling, recent trauma)*: ☐ Yes ☐ No
Neurological symptoms *(such as numbness, headaches, tingling, seizures, muscle weakness):* ☐ Yes ☐ No
Psychiatric issues *(such as depression, anxiety, compulsions)*: ☐ Yes ☐ No
Endocrine symptoms *(such as frequent urination, hot flashes)*: ☐ Yes ☐ No
Hematologic/lymphatic symptoms *(such as bleeding gums, bruising, swollen glands)*: ☐ Yes ☐ No
Allergic/immunologic symptoms *(such as hives, asthma, itching, immune deficiency)*: ☐ Yes ☐ No

Comments related to Review of Symptoms above: _____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:

Have you been immunized: *(check one)* ☐ Yes ☐ No **If yes**, for what illnesses/diseases:

Have you experienced any of the following major medical conditions: *(check all that apply)*

☐ AIDS/HIV	☐ Diabetes	☐ Head Injury	☐ Malaise	☐ Stroke
☐ Arthritis	☐ Diphtheria	☐ Heart Problems	☐ Malaria	☐ TMJ
☐ Blood Disorders	☐ Encephalitis	☐ High Blood Pressure	☐ Measles	☐ Typhoid
☐ Cancer	☐ Fatigue	☐ High Fevers	☐ Meningitis	☐ Vascular Problems
☐ Chicken Pox	☐ Genetic Disorders	☐ Influenza	☐ Mumps	☐ Other: _____
☐ Depression	☐ Headaches		☐ Scarlet Fever	

Do you currently use recreational drugs: *(check one)* ☐ Yes ☐ No

If yes, what drugs: _____

How often: *(check one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you now or have you ever used any tobacco products: *(check one)* ☐ Yes ☐ No ☐ Quit, when: _____

If yes, what do you use: *(circle one)* Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages: *(check one)* ☐ Yes ☐ No

How often: *(check one)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Anything else? _____

HEARING DOCTORS
OF NEW JERSEY

PRIME-MD PHQ
(2 Question Screen)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Yes ☐ No

2. During the past month, have you often been bothered by little interest or pleasure in doing things?

☐ Yes ☐ No

TINNITUS FUNCTIONAL INDEX

Today's Date _____ Your Name _____

Month / Day / Year *Please Print*

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

I Over the PAST WEEK...

1. What percentage of your time awake were you consciously **AWARE OF** your tinnitus?

Never aware ►◉0% ○10% ○20% ○30% ○40% ○50% ○60% ○70% ○80% ○90% ○100% ◄ *Always aware*

2. How **STRONG** or **LOUD** was your tinnitus?

Not at all strong or loud ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Extremely strong or loud*

3. What percentage of your time awake were you **ANNOYED** by your tinnitus?

None of the time ►◉0% ○10% ○20% ○30% ○40% ○50% ○60% ○70% ○80% ○90% ○100% ◄ *All of the time*

SC Over the PAST WEEK...

4. Did you feel **IN CONTROL** in regard to your tinnitus?

Very much in control ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Never in control*

5. How easy was it for you to **COPE** with your tinnitus?

Very easy to cope ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Impossible to cope*

6. How easy was it for you to **IGNORE** your tinnitus?

Very easy to ignore ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ◉7 ○8 ○9 ○10 ◄ *Impossible to ignore*

C Over the PAST WEEK...

7. Your ability to **CONCENTRATE**?

Did not interfere ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Completely interfered*

8. Your ability to **THINK CLEARLY?**

Did not interfere ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Completely interfered*

9. Your ability to **FOCUS ATTENTION** on other things besides your tinnitus?

Did not interfere ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Completely interfered*

SL Over the PAST WEEK...

10. How often did your tinnitus make it difficult to **FALL ASLEEP or STAY ASLEEP**?

Never had difficulty ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Always had difficulty*

11. How often did your tinnitus cause you difficulty in getting **AS MUCH SLEEP** as you needed?

Never had difficulty ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *Always had difficulty*

12. How much of the time did your tinnitus keep you from **SLEEPING** as **DEEPLY** or as **PEACEFULLY** as you would have liked?

None of the time ►◉0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 ◄ *All of the time*

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

A	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere*										*Completely interfered*
13.	Your ability to **HEAR CLEARLY**?	0	1	2	3	4	5	6	7	8	9	10
14.	Your ability to **UNDERSTAND PEOPLE** who are talking?	0	1	2	3	4	5	6	7	8	9	10
15.	Your ability to **FOLLOW CONVERSATIONS** in a group or at meetings?	0	1	2	3	4	5	6	7	8	9	10
R	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere*										*Completely interfered*
16.	Your **QUIET RESTING ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
17.	Your ability to **RELAX**?	0	1	2	3	4	5	6	7	8	9	10
18.	Your ability to enjoy "**PEACE AND QUIET**"?	0	1	2	3	4	5	6	7	8	9	10
Q	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere*										*Completely interfered*
19.	Your enjoyment of **SOCIAL ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
20.	Your **ENJOYMENT OF LIFE**?	0	1	2	3	4	5	6	7	8	9	10
21.	Your **RELATIONSHIPS** with family, friends and other people?	0	1	2	3	4	5	6	7	8	9	10

22. How often did your tinnitus cause you to have difficulty performing your **WORK OR OTHER TASKS**, such as home maintenance, school work, or caring for children or others?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Always had difficulty*

E **Over the PAST WEEK...**

23. How **ANXIOUS** or **WORRIED** has your tinnitus made you feel?

Not at all anxious or worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely anxious or worried*

24. How **BOTHERED** or **UPSET** have you been because of your tinnitus?

Not at all bothered or upset ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely bothered or upset*

25. How **DEPRESSED** were you because of your tinnitus?

Not at all depressed ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely depressed*

INSTRUCTIONS FOR SCORING THE TINNITUS FUNCTIONAL INDEX (TFI)

1. PREPARATION FOR SCORING:

A. **Two items to be transformed:** Items #1 and #3 require a simple transformation from a percentage scale to a 0-10 scale, achieved by dividing the values circled by the respondent by 10. The examiner should write the transformed value in the margin beside the relevant item, preferably using ink of a different color than that used by the respondent.

B. **Ambiguous items:** Because respondents differ in regard to how clearly they circle or mark their answers on the 0-10 scale for each item, the examiner should review every item to resolve any ambiguities. It is helpful if examiners note their decision about each answer in the margin beside the given item, using the differently-colored ink. Some commonly-occurring ambiguities and how to handle them are as follows:

(1) **More than one value marked on the 0-10 scale for a given item**—Typically done by respondents whose tinnitus undergoes large variations over time. The clinic or the examiner should settle on a consistent procedure for all such responses, such as (a) averaging the multiple values indicated for a given item, or (b) marking the item "cannot code", thus removing that item from consideration in the overall TFI score. (The latter choice reduces the information available for calculating the respondent's overall score, and may be desirable only in extremely variable cases where the respondent's reliability is questionable.)

(2) **Respondent marks a value between the 0-10 values on the item scale**— Again, the clinic or the examiner should settle on a consistent procedure for handling all such ambiguous responses in the same way, such as (a) noting a value of 3.5 in the margin, for a respondent who marked the scale between 3 and 4, or (b) collapsing the intermediate value either to the right (to 4) or to the left (to 3).

(3) **Respondent does not make any response to a given item**—The clinic or examiner should decide beforehand how they will indicate missing values, and that notation (e.g. "NA" for "No Answer") should be entered in the margin. If the data will be entered into a computer database, a standard missing value such as "99" can be entered in the margin beside the relevant item. Of course, care must be taken to exclude "99" values if the examiner performs a manual calculation of the overall TFI score.

C. **Unambiguous items:** To facilitate rapid scanning and summing of all valid answers to obtain the respondent's overall TFI score, all of the unambiguous values indicated by the respondent should also be noted in the margin, each such value beside its corresponding item. The examiner can then quickly generate a valid score for the overall TFI.

2. CALCULATION OF OVERALL TFI SCORE:

(1) Sum all valid answers from both TFI pages (maximum possible score = 250 if the respondent were to rate all 25 TFI items at the maximum value of 10).
(2) Divide by the number of questions for which that respondent provided valid answers (yields the respondent's mean item score for all items having valid answers).
(3) Multiply by 10 (provides that respondent's overall TFI score within 0-100 range).

CAUTION—Overall TFI score is **not valid** if respondent **omits 7 or more** items. To be valid as a measure of tinnitus severity, the respondent must answer **at least 19 items** (76% of items).

3. CALCULATION OF SUBSCALE SCORES

The 8 subscales address 8 important domains of negative tinnitus impact as indicated below. Each subscale has a brief title (in capital letters) and a 1- or 2-letter abbreviation (e.g. I for Intrusive , SC for Sense of Control):

SUBSCALE NAME (and conceptual content)	ITEMS IN SUBSCALE
I: INTRUSIVE (unpleasantness, intrusiveness, persistence)	#1, #2, #3
SC: SENSE OF CONTROL (reduced sense of control)	#4, #5, #6
C: COGNITIVE (cognitive interference)	#7, #8, #9
SL: SLEEP (sleep disturbance)	#10, #11, #12
A: AUDITORY (auditory difficulties attributed to tinnitus)	#13, #14, #15
R: RELAXATION (interference with relaxation)	#16, #17, #18
Q: QUALITY OF LIFE (QOL) (quality of life reduced)	#19, #20, #21, #22
E: EMOTIONAL (emotional distress)	#23, #24, #25

Each of the 8 subscales consists of 3 items except for the Quality of life subscale, which consists of 4 items (SEE ITEMS LIST ABOVE). For valid subscale scores, no more than 1 item should be omitted. Computation of subscale scores is as follows:

1) Sum all of that respondent's valid answers for a given subscale.

2) Divide by the number of valid answers that were provided by that respondent for that subscale.

3) Multiply by 10. For the respondent in question, this procedure generates a subscale score in the range 0-100 for each valid subscale.

CAUTION—Do not attempt to compute a respondent's overall TFI score by combining that respondent's valid subscale scores, as the valid subscales may encompass a total number of items that is different from the number of items accepted as valid for the overall TFI score.