

# NeuroDiagnostic Labs

## *VNG Questionnaire*

Please answer all questions by either writing in the answer or circling the correct one.

Patient Name: \_\_\_\_\_

Test Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Medications & Dosage: \_\_\_\_\_

---

### GENERAL SYMPTOMS

When did your symptoms first occur? \_\_\_\_\_

How often do they occur? \_\_\_\_\_

When your symptoms occur; how long do they last? \_\_\_\_\_

Do you experience the sensation of “room-spinning?” Yes No

Do you experience loss of balance, uneasiness, or lightheaded? Yes No

How else would you describe your symptoms? \_\_\_\_\_

Is there any particular movement or position that will start your symptoms or make them worse? Yes No

If yes, please describe \_\_\_\_\_

Do you experience nausea with your symptoms? Yes No

### EARS / SINUS

Do you have any ringing in the ears? Yes No

If yes, which ear? Left Right Both

If both ears, which ear is greater? Left Right Equal

Have you had a pressure or fullness type sensation in your ears? Yes No

(some describe it as feeling like they have been swimming or flying, or they feel like they want to “pop” their ears)

If yes, which ear? Left Right Both

If both ears, which ear is greater? Left Right Equal

Do you have any pain in your ears? Yes No

If yes, which ear? Left Right Both

If both ears, which ear is greater? Left Right Equal

Do you experience sudden hearing loss with your symptoms? Yes No

If yes, which ear? Left Right Both

If both ears, which ear is greater? Left Right Equal

Have you had:      Sinus Infection      Ear Infection      Congestion      Sinus Pressure      None

If so, when was the last time and for how long? \_\_\_\_\_

**HEAD**

Do you experience blurred or double vision with your symptoms?      Yes      No

Have you had any head trauma?      Yes      No

If so, when and what happened? \_\_\_\_\_

Have you had a stroke or TIA (mini-stroke)?      Yes      No

If so, when and what happened? \_\_\_\_\_

Do you experience headaches with your symptoms?      Yes      No

Do you have a history of migraines?      Yes      No

**OTHER**

Do you smoke?      Yes      No

If so, how much, and when (date and time) was your last? \_\_\_\_\_

How is your blood pressure?      High      Low      Normal

Do you treat it with medication?      Yes      No

Do you have any heart or cardiovascular problems?      Yes      No

If yes, please explain. \_\_\_\_\_

Any other information you feel is pertinent for the technologist or doctor to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Patient or guardian:** \_\_\_\_\_

**For Office Use Only**

Additional Tech Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring MD: \_\_\_\_\_      Tech : \_\_\_\_\_



**PATIENT INFORMATION**  
**NeuroDiagnostic**  
Laboratories

\*\*\*Please Print\*\*\*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

In case of emergency, name & phone number of nearest relative \_\_\_\_\_ ( ) \_\_\_\_\_

Drivers License # and State \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex: Male Female Marital Status: S M D W Name of Spouse \_\_\_\_\_

Primary Care Physician's Name \_\_\_\_\_ Phone( ) \_\_\_\_\_

**GUARANTOR INFORMATION – Must be completed (Patient &/or Responsible Party):**

Responsible party / Guarantor Name \_\_\_\_\_ Guarantor Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ Phone( ) \_\_\_\_\_

City & State & Zip \_\_\_\_\_ SS# \_\_\_\_\_

**WORKER'S COMPENSATION/AUTO ACCIDENT CLAIM: YES NO**

Insurance Carrier \_\_\_\_\_ Carrier Address \_\_\_\_\_

Claim # \_\_\_\_\_ DOI: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adjuster's Name \_\_\_\_\_ Adjuster's Phone( ) \_\_\_\_\_

**INSURANCE INFORMATION: PRIMARY** (A valid Insurance card is required in order to bill)

Insurance Carrier \_\_\_\_\_ Insurance Group Number \_\_\_\_\_

Guarantor on Policy \_\_\_\_\_ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer \_\_\_\_\_ Address \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Plan ID # \_\_\_\_\_ Plan Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Annual Deductible Amount \$ \_\_\_\_\_ Co-Pay Amount \$ \_\_\_\_\_ Has patient's deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other

**INSURANCE INFORMATION: SECONDARY** (A valid Insurance card is required in order to bill)

Insurance Carrier \_\_\_\_\_ Insurance Group Number \_\_\_\_\_

Guarantor on Policy \_\_\_\_\_ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer \_\_\_\_\_ Address \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Plan ID # \_\_\_\_\_ Plan Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Annual Deductible Amount \$ \_\_\_\_\_ Co-Pay Amount \$ \_\_\_\_\_ Has **patient's** deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other

## Consent for Videonystagmography (VNG)

Videonystagmography (VNG) has become the standard for consistently testing deficiencies, defects, and diseases of the inner ear and central vestibular functions. These conditions can lead to general unsteadiness and balance problems. The VNG test is the most accurate test available today that can help determine the presence and location of a vestibular abnormality.

A VNG test measures eye movements via a pair of special goggles and infrared cameras. The patient will be asked to follow moving lights, look from one point to another, make rapid postural changes, and to have cool or warm air placed in the ear canals to stimulate the balance mechanism of the inner ear. A VNG is a non-invasive test with only minimal discomfort.

While performing this test, your symptoms may become exaggerated and you may become dizzy, nauseated, and/or weak. Care will be given to ensure you do not fall down. The level or severity of these symptoms depends on the reason for your test and are only temporary usually lasting seconds to minutes. There are no lasting side effects caused by VNG testing.

I have read the above information about the procedure I will undergo today. My questions and concerns about the VNG test have been answered by this form and/or the technologist performing the test. I acknowledge the above information and desire to proceed with the test. I also understand that I can stop the test at any time for any reason.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Technician/Witness Signature

FINANCIAL POLICY

Benefits are determined once a claim is received by your insurance company. Our facility will provide the service of billing your medical insurance company; however, as the patient and/or responsible party, you are responsible for providing us with **ALL** the **CORRECT** and **COMPLETE** information regarding medical insurance coverage at the time of service. It is also the responsibility of the patient and/or responsible party to pay for all co-payments, deductibles, and/or co-insurance amounts, if required by your insurance policy. If the insurance company denies the claim for services rendered due to reasons for which we cannot appeal, you understand that the balance will then become your responsibility.

As a cash paying patient, you are aware that half of the payment for services rendered are due at the time of service and payment arrangements may be made for the remaining balance.

A non-sufficient funds (NSF) fee of \$25 will be applied to any returned check and then we will only accept cash, credit card, or money order for any and all payments thereafter.

If you fail to pay any amount owed within the time allotted, your account will be sent to a collections agency and you understand that you will then owe the amount for services rendered plus any and all collection costs and attorneys fees.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to AMDx, LTD/Neurodiagnostic Laboratories, LLC and or/it's affiliated entities or otherwise at its direction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by AMDx, LTD/Neurodiagnostic Laboratories, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by AMDx,LTD/Neurodiagnostic Laboratories, LLC.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY,  
ASSIGNMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE INFORMATION

Print Patient/Responsible Party Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_