KEY HEARING and BALANCE

# Patient Intake Packet

Vestibular Wellness Program

Dr. Leah Keylard, Au.D. | Vestibular Audiologist | (425) 277-9521
4300 Talbot Rd S, Suite 313 | Renton, WA 98055 | keyhearing.com

*Please complete all sections before your first session. Read each agreement carefully and sign where indicated. All information is confidential and retained in your patient record.*

## Patient Information

**Patient Name:** _____ **Date of Birth:** _____

**Home Phone:** _____ **Mobile Phone:** _____ **Age:** _____

**Email Address:** _____

☐ Receive Key Hearing & Balance newsletter and updates (uses email address above)

**Address:** _____ **City:** _____ **State / ZIP:** _____

**Work Phone:** _____ **Emergency Contact:** _____

**Relationship:** _____ **Emergency Contact Phone:** _____

**Preferred contact method for appointment reminders:**

☐ Email ☐ Mobile / SMS

☐ Home Phone ☐ Work Phone

## Referring and Treating Physicians

**Referring Physician:** _____ **Phone:** _____

**Primary Care Physician:** _____ **Phone:** _____

Release of Medical Information to Providers Today's visit results will be sent to your referring provider. If you would like records forwarded to an additional provider, list them below. Your signature below authorizes this release.

**Additional provider (if any):** _____ **Your Signature:** _____

**How did you hear about us?** _____ **May we thank a referring person?** _____

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## Reason for Visiting

**Primary goal — check all that apply:**

- ☐ Better sleep quality
- ☐ Balance improvement / fall prevention
- ☐ Athletic / performance enhancement
- ☐ ADHD support
- ☐ General wellness
- ☐ Sharper focus / mental clarity
- ☐ Post-concussion recovery
- ☐ Reduce dizziness or vertigo
- ☐ Autism Spectrum support
- ☐ Other (describe below)

| *Describe your primary reason for seeking this program in your own words:* |
|---|
| |
| |

## Current Symptoms

**Check any symptoms you currently experience:**

- ☐ Dizziness or vertigo
- ☐ Difficulty sleeping
- ☐ Poor concentration or focus
- ☐ Tunnel vision / visual disturbance
- ☐ Nausea
- ☐ Anxiety or emotional dysregulation
- ☐ Stimming or repetitive behaviors
- ☐ Ear ringing (tinnitus)
- ☐ Poor balance / unsteadiness
- ☐ Brain fog / slow thinking
- ☐ Headaches
- ☐ Sensitivity to light or sound
- ☐ Fatigue
- ☐ Difficulty with memory or recall
- ☐ Motion sensitivity (car, screens)
- ☐ None of the above

**How long have you experienced these symptoms?**

- ☐ Less than 1 month
- ☐ 1 to 6 months
- ☐ 6 to 12 months
- ☐ 1 to 3 years
- ☐ More than 3 years
- ☐ Ongoing / lifelong

**Self-rated balance on a typical day:**

☐ 1 Very poor ☐ 2 Poor ☐ 3 Fair ☐ 4 Good ☐ 5 Excellent

## Medical History

**STOP: If you answer YES to questions 1, 2, 3, or 4, you are NOT eligible to participate. Please inform the front desk before continuing.**

| | | |
|---|---|---|
| 1. Do you have epilepsy or a seizure disorder? | ☐ Yes | ☐ No |
| 2. Have you had a concussion or head injury within the past 7 days? | ☐ Yes | ☐ No |
| 3. Are you currently experiencing active nausea or vomiting? | ☐ Yes | ☐ No |
| 4. Do you have a pacemaker or implanted cardiac device? | ☐ Yes | ☐ No |

**Continue with the questions below (if none of the first 4 are yes):**

*If you answer YES to any question below, do not self-exclude. Dr. Keylard will review your response and advise whether participation is appropriate before treatment begins.*

5. Do you have a diagnosis of Meniere's disease or severe vestibular disorder? ☐ Yes ☐ No
6. Have you had any surgery within the past 6 months? ☐ Yes ☐ No
7. Do you have uncontrolled high blood pressure or heart disease? ☐ Yes ☐ No
8. Are you currently pregnant? ☐ Yes ☐ No
9. Do you have a significant neck or spine injury or condition? ☐ Yes ☐ No
10. Do you have severe anxiety that may be triggered by rotational movement? ☐ Yes ☐ No
11. Are you currently receiving vestibular physical therapy or balance treatment? ☐ Yes ☐ No **If yes where:** _____
12. Have you received vestibular rehabilitation or spinning therapy before? ☐ Yes ☐ No **If yes where:** _____

**13. Prescription medications — please list any taken on a regular basis:**

| Medication | Condition or reason |
|---|---|
| | |
| | |
| | |
| | |

**14. Please check any of the following conditions you currently have or have had in the past:**

☐ High Blood Pressure
☐ Heart Trouble
☐ Stroke or TIA
☐ Diabetes
☐ Parkinson's Disease
☐ Bell's Palsy
☐ Neurological Symptoms
☐ Head Injury
☐ Meningitis
☐ Visual Trouble / Loss of Sight
☐ None of the above

## Known allergies:

| *Other medical history, surgeries, or conditions we should know about:* |
|---|
| |
| |
| |

## Prior Treatment and Activity Level

**Prior treatment received - check all that apply:**

- ☐ Vestibular physical therapy
- ☐ Concussion rehabilitation
- ☐ ADHD treatment (medication or therapy)
- ☐ Occupational therapy (sensory)
- ☐ Balance or fall prevention program
- ☐ None of the above

**Current activity level:**

☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active ☐ Competitive athlete

## Your Goals

| *What specific improvements matter most to you by the end of this program?* |
|---|
| |
| |

| *Anything else you would like Dr. Keylard to know before your first session?* |
|---|
| |
| |

# Financial Agreement and Program Terms

*Cash-Pay Wellness Program • Out-of-Pocket Service Only • Please read carefully before signing.*

## Program Selection

**Please check one:**

☐ **Founding Client Program**
$500 total | 6 sessions | approx. 3 weeks
2 sessions per week maximum
Full payment at enrollment

☐ **Standard Program**
$1,000 total | 12 sessions | 6 weeks
2 sessions per week maximum
Full payment at enrollment

*For the full session schedule and description of what is included in each tier, see the Informed Consent section of this packet.*

## Payment Terms

**Payment method:**

- ☐ Credit card
- ☐ Debit card
- ☐ Cash
- ☐ Check (payable to Key Hearing & Balance)

Payment is collected in full at the time of enrollment. The vestibular wellness program at Key Hearing & Balance is a cash-pay, out-of-pocket service. We do not bill insurance for this program. Patients are responsible for the full program fee regardless of any insurance coverage or personal circumstances.

**I (print name):**

hereby authorize treatment and agree to pay all fees. I understand that Key Hearing & Balance may release any medical information as authorized. I acknowledge that failure to meet my financial obligations may result in referral of my account to a collections process.

## Refund and Cancellation Policy

ALL SALES ARE FINAL — NO REFUNDS Program fees are non-refundable once payment has been collected, regardless of the reason for discontinuation, including personal circumstances, relocation, schedule conflicts, or voluntary withdrawal.

**Session scheduling and cancellation:**

- Sessions must be scheduled in advance through the clinic
- Please provide at least 24 hours notice to cancel or reschedule
- Late cancellations (under 24 hours) and no-shows forfeit that session and it counts as used
- Sessions expire at the end of your program period and may not be carried forward or transferred to another person

**Medical withdrawal:**

If a patient is medically unable to continue due to a documented contraindication identified after enrollment, Key Hearing & Balance may, at its sole discretion, offer a partial credit toward a future program. This is not a guarantee and must be requested in writing.

## Patient Acknowledgment

By signing below, I confirm I have read and understood the program terms, payment policy, and no-refund policy. I agree to these terms as a condition of enrollment.

- I understand this is a cash-pay wellness program not billed to insurance
- I understand the full program fee is due at enrollment and is non-refundable
- I understand that missed or late-cancelled sessions are forfeited

**Patient Signature** **Date:**

**Printed Name:** **Staff Initials:**

**Tier:** **Payment confirmed:** **Start date:**

# Informed Consent — Vestibular Wellness Program

*Please read all sections and initial each acknowledgment before signing.*

## Program Description

The vestibular wellness program at Key Hearing & Balance uses the Spin the Brain RAIL System to deliver supervised rotational vestibular stimulation. The program supports improvements in balance, cognitive function, sleep quality, and neurological performance through repeated, graduated sessions under clinical supervision.

**Session structure by program:**

| Session | Founding Client ($500 • 6 sessions • 3 wks) | Standard Program ($1,000 • 12 sessions • 6 wks) |
|---|---|---|
| First session (approx. 30-60 min) | mCTSIB balance baseline + AXON cognitive baseline + spin training + progress review<br>*Dr. Keylard conducts* | mCTSIB balance baseline + AXON cognitive baseline + spin training + progress review<br>*Dr. Keylard conducts* |
| Sessions 2–5 (approx. 15 min) | Abbreviated cognitive + spin + cognitive sequence<br>*Cathy or designee* | Abbreviated cognitive + spin + cognitive sequence<br>*Cathy or designee* |
| Session 6 (30–60 min; may be longer) | Full balance & cognitive re-assessment + clinician results review<br>*Dr. Keylard conducts* | Abbreviated cognitive + spin + cognitive sequence<br>*Cathy or designee* |
| Sessions 7–11 (approx. 15 min) | Program complete after session 6 | Abbreviated cognitive + spin + cognitive sequence<br>*Cathy or designee* |
| Session 12 (30–60 min; may be longer) | — | Full balance & cognitive re-assessment + clinician results review<br>*Dr. Keylard conducts* |

*Frequency: Up to 2 sessions per week. Optimal results occur with consistent participation throughout the program.*

*This program is a wellness service. It is not a substitute for medical diagnosis, treatment, or physical therapy. It does not treat, cure, or prevent any medical condition. Individual results vary.*

## Contraindications

Contraindication screening was completed in the Medical History section of this packet. Absolute stops (epilepsy or seizure disorder; concussion or head injury within 7 days; active nausea or vomiting; pacemaker or implanted cardiac device) and all additional disclosure conditions are on file. Dr. Keylard will review any conditional disclosures before advising treatment. Please confirm below before signing.

Please initial below to confirm none of the four absolute contraindications apply to you:

| Initial | |
|---|---|
| _____ | I confirm I do not have epilepsy, am not within 7 days of a head injury, am not experiencing active nausea or vomiting, and do not have a pacemaker or implanted cardiac device. |

## Risks and Possible Side Effects

The spinning protocol is graduated and clinician-supervised. Most patients tolerate it well. The following transient effects may occur:

- Brief dizziness or nausea immediately following a session - typically resolves within minutes
- Mild disorientation or light-headedness
- Fatigue after early sessions as your vestibular system adapts

If you experience unexpected or prolonged discomfort, dizziness not resolving within 15 minutes, or any new or concerning symptoms, contact the clinic immediately at (425) 277-9521.

*Emergency protocol: In the event of a medical emergency, staff will call 911 immediately. Clinical oversight is provided by Dr. Leah Keylard, Au.D. Medical director consultation is available through Spin the Brain Medical Director, Dr. Dan O'Brien.*

## Consent and Acknowledgment

**Please initial each line:**

| | |
|---|---|
| Initial | I understand the financial terms and payment policy covered in the Financial Agreement I am signing today. |
| Initial | I understand this program does not treat, cure, or diagnose any medical condition, and that individual results vary. |
| Initial | I confirm I have disclosed all relevant medical conditions and do not have any absolute contraindications listed above. |
| Initial | I understand the protocol is supervised and the clinician may modify or discontinue my participation based on my response. |
| Initial | I have been given the opportunity to ask questions and have had them answered to my satisfaction. |
| Initial | I voluntarily consent to participate in the vestibular wellness program at Key Hearing & Balance. |

By signing below, I confirm I have read this consent form in full, had the opportunity to ask questions, and voluntarily agree to participate in the vestibular wellness program at Key Hearing & Balance.

**Patient Signature** _____ **Date:** _____

**Printed Name:** _____

**Dr. Leah Keylard, Au.D. - Clinician Signature** _____ **Date:** _____

*A copy of this signed consent will be retained in your patient record. Request a copy for your own records if desired.*

## Notice of Privacy Practices

*Effective January 1, 2026 • Please review carefully.*

Key Hearing & Balance PLLC respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to obtain your authorization to disclose this information for payment purposes.

### How We Use and Disclose Your Health Information

**For treatment:**

- Information obtained by our health care team will be recorded in your medical record and used to determine what care may be right for you.
- We may provide information to others involved in your care to help them stay informed.

**For payment:**

- We may request payment from your health insurance plan. Information provided to health plans may include diagnoses, procedures performed, or recommended care.

**For health care operations:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review clinician qualifications and train staff.
- We may contact you to remind you about appointments or provide information about treatment alternatives.
- We may use and disclose your information for accounting, legal, risk management, and insurance services, and for audit functions including fraud and abuse detection.

### Your Health Information Rights

The health and billing records we create and store are the property of Key Hearing & Balance PLLC. The protected health information in them generally belongs to you. You have the right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. Requests must be submitted in writing.
- Request and receive a paper copy of the most current Notice of Privacy Practices.
- Request to see and obtain a copy of your protected health information. Requests must be submitted in writing.
- Have us review a denial of access to your health information, except in certain circumstances.
- Ask us to amend your health information. Requests must be submitted in writing.
- Request a list of disclosures of your health information. You may receive this without charge once every 12 months.
- Ask that your health information be delivered by another means or to another location. Please submit this request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information already released or actions already taken.

For assistance with these rights during normal business hours, please contact: Dr. Leah Wilkinson Keylard (425) 277-9521

## Our Responsibilities

We are required to keep your protected health information private, provide you this Notice, and follow the terms of this Notice. We have the right to change our privacy practices. If we make changes, we will update this Notice. You may receive the most current copy by calling us or visiting our office.

## Other Disclosures

We may release health information about you to a friend or family member involved in your medical care, unless you object. We may use and disclose your protected health information without authorization as permitted or required by law, including:

- With medical researchers whose research has been approved and includes policies to protect privacy.
- To comply with Workers' Compensation laws.
- For public health and safety purposes as allowed or required by law.
- To report suspected abuse or neglect to public authorities.
- For law enforcement purposes, such as responding to a subpoena or court order.
- For health and safety oversight activities, such as sharing information with the Department of Health.
- For disaster relief purposes.
- For judicial or administrative proceedings at your request or as directed by court order.
- For specialized government or national security functions as required.

All other uses and disclosures not described in this Notice will be made only as allowed or required by law, or with your written authorization.

## Questions or Complaints

If you have questions, want more information, or want to report a concern about the handling of your protected health information, please contact: Dr. Leah Wilkinson Keylard, Privacy Officer • (425) 277-9521 • 4300 Talbot Rd S, Suite 313, Renton, WA 98055

You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint and will not retaliate against you for doing so. This Notice is also available at keyhearing.com.

Acknowledgment of Receipt We keep a record of the health care services we provide you. You may ask to see and copy that record, and you may ask to correct it. We will not disclose your record to others unless you direct us to do so or unless the law requires it. By signing below, I acknowledge that I have received the Notice of Privacy Practices for Key Hearing & Balance PLLC.

**Patient or Authorized Representative Signature** _____ **Date:** _____

**Printed Name:** _____

*This form will be retained in your medical record. Last updated: March 2026*

## Medical Release and Authorizations

*Please read each section carefully and sign where indicated.*

### Section 1 — Medical & Participation Release

*I recognize that vestibular training and balance therapy activities involve physical movement and sensory stimulation. I acknowledge that these activities carry an inherent risk of dizziness, nausea, falls, or other physical reactions. I voluntarily choose to participate in the vestibular training program offered by Key Hearing & Balance under the supervision of Dr. Leah Keylard, Au.D., CCC-A.*

I represent that I am in adequate physical and medical condition to participate, and I have disclosed all relevant medical history, medications, and conditions in this intake packet. I agree to notify Key Hearing & Balance immediately if my medical condition changes.

To the fullest extent permitted by law, I, on behalf of myself and my heirs, assigns, and legal representatives, release, discharge, and hold harmless Key Hearing & Balance, Dr. Leah Keylard Au.D., their employees, agents, and affiliates from any and all claims, demands, damages, losses, or liabilities arising from my participation in vestibular training services, including any injury or adverse reaction, whether or not caused by the negligence of Key Hearing & Balance.

**Please select one:**

☐ I AUTHORIZE use of my de-identified (anonymous) balance data as described above.

☐ I DO NOT authorize use of my balance data.

**Patient or Authorized Representative Signature** _____ **Date:** _____

### Section 2 — Permission to Use Photo & Video Images

*In consideration for the services received, I grant Key Hearing & Balance the right and unrestricted permission to photograph or record video images of me during my participation in vestibular training sessions.*

These images and recordings may be used for purposes including, but not limited to: clinical documentation, patient education materials, social media platforms (including YouTube and Instagram), website content, marketing publications, professional presentations, and research.

Key Hearing & Balance will not publicly associate my name with any image or video posted to social media or published in marketing materials without my separate written consent. My image or session footage may appear without my name.

I release Key Hearing & Balance, Dr. Leah Keylard Au.D., and their agents and assigns from any and all claims arising from the use of such images or recordings, including claims of invasion of privacy, right of publicity, or defamation.

**Please select one:**

☐ I GRANT permission to use my photo and video images as described above.

☐ I DO NOT grant permission to use my photo and video images.

**Patient Signature** _____ **Date:** _____

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## Section 3 — Authorization to Use Balance Assessment Data

*During your participation in vestibular training, Key Hearing & Balance uses the Balance Tracking System (BTrackS) to record objective balance and postural stability measurements. These measurements are a routine part of your clinical care.*

By signing below, I authorize Key Hearing & Balance to use de-identified records from my balance assessments for the following purposes:

- Anonymous case studies used in patient education, professional presentations, or published materials. No identifying information will appear.
- Aggregate program outcome reporting, where individual records cannot be traced to any patient.

De-identified data means all information that could directly identify you (name, date of birth, address) is removed before any use outside your individual care record. Your assessment data is stored on clinic systems only and is not transmitted to third parties. This authorization is voluntary. Declining will not affect the quality of care you receive at Key Hearing & Balance.

*This authorization is separate from, and in addition to, the Notice of Privacy Practices above. You may revoke this authorization at any time in writing; revocation does not affect records already used in completed case studies or reports.*

**Please select one:**

☐ I AUTHORIZE use of my de-identified (anonymized) balance data as described above.

☐ I DO NOT authorize use of my balance data.

**Patient Signature** _____ **Date** _____

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## For Clinical Use Only (Please Leave Blank)

| | |
|---|---|
| **Program Tier** | ☐ Founding Client ($500 / 6 sessions)<br>☐ Standard Program ($1,000 / 12 sessions) |
| **Contraindication Screening** | ☐ Cleared for participation<br>☐ Hold — requires clinician review |
| **mCTSIB Baseline** | _____ cm composite / _____ percentile<br>Date: _____ |
| **AXON Cognitive Baseline** | Processing speed: _____<br>Date: _____ |

**Clinician intake notes:**

**Clinician Signature** _____ **Date** _____