WELLNESS PHYSICAL
MEDICINE CENTER

PREPARATIONS FOR EMG TESTING:

Wellness Physical Medicine Center
Tests are performed by: Dr. Mark Brennan MD

Here are some instructions for preparing for and undergoing an electromyography (EMG) test:

- Please avoid using any oils, creams, lotions, or sprays on your neck & arms for upper extremity EMG & avoid using all of the above mentioned on your back & legs for a lower extremity EMG.

- Wear loose clothing: Wear loose-fitting clothing and you may be given a hospital gown to wear. We recommend wearing pants that are able to pull up above your knee for a lower extremity EMG.

- Take medication: Continue taking any medications you are taking unless otherwise instructed by your doctor. Some medications, such as muscle relaxants, can interfere with the test results, so you may need to stop taking them before the test. (Please notify the staff of all medications)

- Eat normally: You can eat your normal meal on the day of the test.

During the test, you may experience minor/moderate pinches on the affected body parts, a slight discomfort. Results will be verbally explained to you during your visit as well as you will leave a written copy of the test results.

Wellness Physical
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EMG QUESTIONNAIRE

1. Are you currently on coumadin or any other blood thinners? YES NO
2. Do you have a defibrillator? YES NO
3. Do you have a pacemaker? YES NO

INFORMED CONSENT FORM FOR EMG TESTING:

By signing below, I acknowledge Dr. Mark Brennan has informed me of the risks associated with EMG testing while on medications that thin my blood.

By signing below, I am aware of these risks and wish to proceed with the EMG testing, **or I am not on any such medications**.

______________________________ ____________________
Printed Name of Patient: Date:

______________________________ ____________________
Signature of Patient: Date:

______________________________ ____________________
Signature of Witness: Date:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE HEALTHCARE INFORMATION DISCLOSURE

Wellness Physical Medicine Center

By signing below, I acknowledge that I have received a notice of privacy practices from: Wellness Physical Medicine Center.

I consent (the above named organization) to disclose and receive pharmacy clearinghouse healthcare information. This request is effective until revoked by the beneficiary.

Wellness Physical Medicine Center have consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

__________________________________ ________________

Printed Name of Patient: Date:

__________________________________ ________________

Signature of Patient: Date:

__________________________________ ________________

Witness (Staff Member) Date:

Wellness Physical Medicine Center
Patients' Right to Privacy

This notice describes how medical information about you may be disclosed and how you obtain access to the information. Please review it carefully. It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable laws. If you receive this notice via website or by email, you are also entitled to receive this notice in written form from our office.

Healthcare Privacy:
Each time you visit a hospital, physician or other healthcare providers, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

Privacy Practices for Protected Health Information:
The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patients' ability to trust the information shared will be protected and kept confidential.

Consent Agreement:
Providing "Consent" allows for the use and disclosure of protected health information only for treatment, payment and healthcare operations.
As part of your healthcare, we originate and maintain health records describing your health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

This information is a Basis For:

- Planning a future care or treatment
- A means of communication among many health professionals who contribute to your care
- A source of information for applying your diagnosis and medical information to your bill
- A means by which a third-party payer can verify that services were billed were actually provided
- A tool routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner in the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of our information
- Obtain a paper copy of this notice upon request
- Inspect a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures
- Request communication of your health information by alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken
- Receive notification if ever there is a breach of unsecured public health information

You have the right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcome. If you and your doctor cannot agree about your care, which meets ethical and professional standards, you may be asked to seek treatment elsewhere.

RELEASE OF INFORMATION

Each time you are seen by a medical professional, a written report is generated detailing your visit and treatment recommendations. We need your signed authorization to release medical information. Please complete the information below.

1. Who referred you to our office? Please note, if this area is completed, a written report MUST be sent.
   Name:____
   Address:_______________________________________
   ____
   Phone:____
2. Do you have a primary care (family) physician?
   Name:____
   Address:_______________________________________
   ____
   Phone:____
3. Can we speak to family members/other individuals regarding your medical condition? Yes______
   No______
   Name:__________________________Relationship:__________________
   Name:__________________________Relationship:__________________
4. By initialing here, you do **NOT** want medical information released to anyone ________________

PLEASE NOTE: By law, we must send our reports to Workers Compensation or Auto Insurance carriers if your care is related to a work or auto injury

I, confirm all information listed on this sheet is correct to the best of my knowledge. This authorization will stay in effect until revoked by myself.

____ ____________________
Print Name Date

____ ____________________
Patient Signature Date

____ ____________________
Witness Date