EMG QUESTIONAIRE

1. Are you on currently on Coumadin? 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. Martha Frankowski has informed me of the risks associated with EMG testing while on the medication to thin my blood such as Coumadin, Warafin, Plavix; and any other blood thinning medications.

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.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

PLEASE SEE REVERSE SIDE FOR TESTING PREPARATIONS.

PREPARATIONS FOR EMG, EEG, AND EVOKED POTENTIAL TESTING:

EMG: Patient must have clean skin. Please wear your undergarments, you will be asked to put on a patient gown. No oils or lotions are to be used on the arms and legs prior to the testing. *Please see reverse side*.

SSEP: Patient must have clean skin and hair. Please wear your undergarments, you will be asked to put on a patient gown. Do not use hairspray, mousse, gels, or oils in hair.

BAER/
AEP: Patient must have clean hair. Do not use hairsprays, mousse, gels, or oils in hair.

VEP: Patient must have clean hair. Do not use hairsprays, mousse, gels, or oils in hair.

EEG: Patient must have clean hair. Please wear a loose fitting blouse/shirt. Do not use hairspray, mousse, gels, oils in hair. All hair weaves and braids must be removed prior to testing.

24 HR EEG: Patient must have clean hair. Please wear a loose fitting blouse/shirt. Do not use hairspray, mousse, gels, oils in hair. All hair weaves and braids must be removed prior to testing. You will be sent home with the electrodes pasted and wrapped up on your head. You are responsible for returning the machine the next day ON TIME. *PREP TIME: Approx. 45 mins. TESTING TIME: Approx. 24 hrs*

SLEEP DEPRIVED EEG:

Patient must stay awake from 12:00 A.M. until scheduled appointment time. Patient must also have clean hair. Do not use hairsprays, mousse, gels, or oils in hair. All hair weaves and braids must be removed prior to testing.

Please bring your insurance cards and your prescription from your physician requesting your test. You must bring in a referral from your primary care physician if your insurance company requires one. Your appointment will be rescheduled if this is not provided and/or if you arrive more than twenty minutes late than your scheduled appointment time.

UNLESS OTHERWISE INSTRUCTED BY YOUR PHYSICIAN, CONTINUE TAKING PRESCRIBED MEDICATIONS.

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. **Can we speak to family members/other individuals regarding your medical condition?**
   Yes_____**No**_____

   If you have answered yes to the above, please list the name and relationship of this individual.

   Name:_____**Relationship:**_____

   Name:_____**Relationship:**_____

3. **By initialing here, you do NOT want medical information released to anyone.**_____

PLEASE NOTE: By law, we must send our reports to Workers Compensation and 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**

Patient's Right to Privacy
The Neurosurgery Group. P.C.
Neurology Specialist
Sleep and Live Well Diagnostic Center
Wellness Physical Medicine

Healthcare Privacy

Each time you visit a hospital, physician or other healthcare provider, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination and 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 Protective 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 patient's ability to trust that the information shared will be protected and kept confidential. Yet, many patients are concerned that their information is not protected.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner in the facility that complied 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 communications 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.

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 ad 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 for 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 billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Confidentiality

Expect that all aspects of your care will be confidential. Your medical records, both written and electronic, will not be released without your written permission, unless it is associated within our healthcare operations. These operations include but are not limited to; evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs. Our office many use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you. Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

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.
- Pay out of pocket for a service and the right to require that we not submit PHI to your individual health plan.

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 any time as long as the changes are in accordance with applicable laws. If you receive this notice via our website or by e-mail, you are also entitled to receive this notice in written form from our office.

AKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE
HEALTHCARE INFORMATION DISCLOSURE
Wellness Physical Medicine

By signing below, I acknowledge that I have received a notice of the privacy practices of The Neurosurgery Group, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center located on the back of this sheet.

Patient Declined _____ Date _____ _____Initials

I understand once (the above named organizations) has disclosed the healthcare information I have authorized to be disclosed, (above named organizations) has no control over the information. The person or organization I have authorized to receive the information might also disclose the information, and it may no longer be protected by privacy laws. This request is effective until revoked by the beneficiary. By declining to sign you will be required to pay for treatment in full at time of service.

Patient Declined _____ Date _____ _____Initials

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

_____Initials

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, as well as all insurance companies, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payments to medical insurance benefits to the party who accepts the assignment for services rendered by this provider. This request is effective until revoked by beneficiary. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

The Neurosurgery Group, P.C, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center have my consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Witness (Staff Member) Date