

### **Welcome!**

**Thank you for choosing the Berman Brain & Spine Institute  
and LifeBridge Health for your healthcare needs.**

You are scheduled for an **electroencephalogram (EEG)**

on \_\_\_\_\_, \_\_\_\_\_, 20 \_\_\_\_\_ at \_\_\_\_\_  am  
*day of the week month and day*  pm

You are expected to arrive at your registration time \_\_\_\_\_  am  
 pm

**The neurodiagnostic center is on the 2<sup>nd</sup> floor of 5051 Greenspring Avenue**

➡ You will receive an automated reminder call 48 hours prior to your appointment.

### **Things You Must Know or Do**

1. Read the pages of this packet for **important instructions concerning EEGs**
2. Complete and sign the forms on pages 5–10 of this packet **before** your visit and bring them with you when you come (**do not mail them**).
3. If your insurance company requires you to obtain a referral, **it is your responsibility to obtain your referral.**
4. We cannot perform an EEG on people with **hair tracks, certain braid styles (not including single braids), or hair pieces that are not removable.** If you have any questions, **please call 410-601-5709 prior to your appointment day.**
5. For your appointment, wear **buttoned or zipped clothing that does not need to be removed by pulling over your head.**
6. Our building does NOT have an ATM machine. Bring cash or credit card (Visa, Master Card, or Discover—NOT American Express) for parking (with validation, the parking fee is \$3).
7. **Minors must be accompanied by an authorized adult.**
8. If you do not arrive for your appointment in sufficient time to allow for registration or if you do not bring a required referral, **your appointment may be rescheduled.**
9. To print more copies of this packet, go to [www.lifebridgehealth.org/NeurologyAppointments](http://www.lifebridgehealth.org/NeurologyAppointments).

### **Things You Must Bring**

1. Insurance card
2. Photo ID
3. Referral, if necessary, and/or authorization from requesting physician
4. Completed and signed pages of this packet—pages 5–10
5. A list of current medications (page 10 of this packet) or bring your medication bottles

If you have any questions, contact us at **410-601-9755** or **[bsiphsicians@lifebridgehealth.org](mailto:bsiphsicians@lifebridgehealth.org)**.

## Directions to the Michel Mirowski Medical Office Building

5051 Greenspring Avenue • Baltimore, MD 21209 • 410-601-4417

The clinic in the Mirowski Building is on the 2<sup>nd</sup> floor.

**From the Northwest** — From Carroll County, Owings Mills or Reisterstown, take I-795 to I-695 East (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. **Look below for directions from Northern Pkwy.**

**From the North** — From Pennsylvania and northern Baltimore suburbs, take I-83 South. At junction with I-695 (Baltimore Beltway), enter I-695 heading West (Pikesville direction). Re-enter I-83 South at Exit 23. Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. **Look below for directions from Northern Parkway.**

**From the West** — From Howard County and points west, head east on I-70 or on I-795 to I-695 East (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. **Look below for directions from Northern Parkway.**

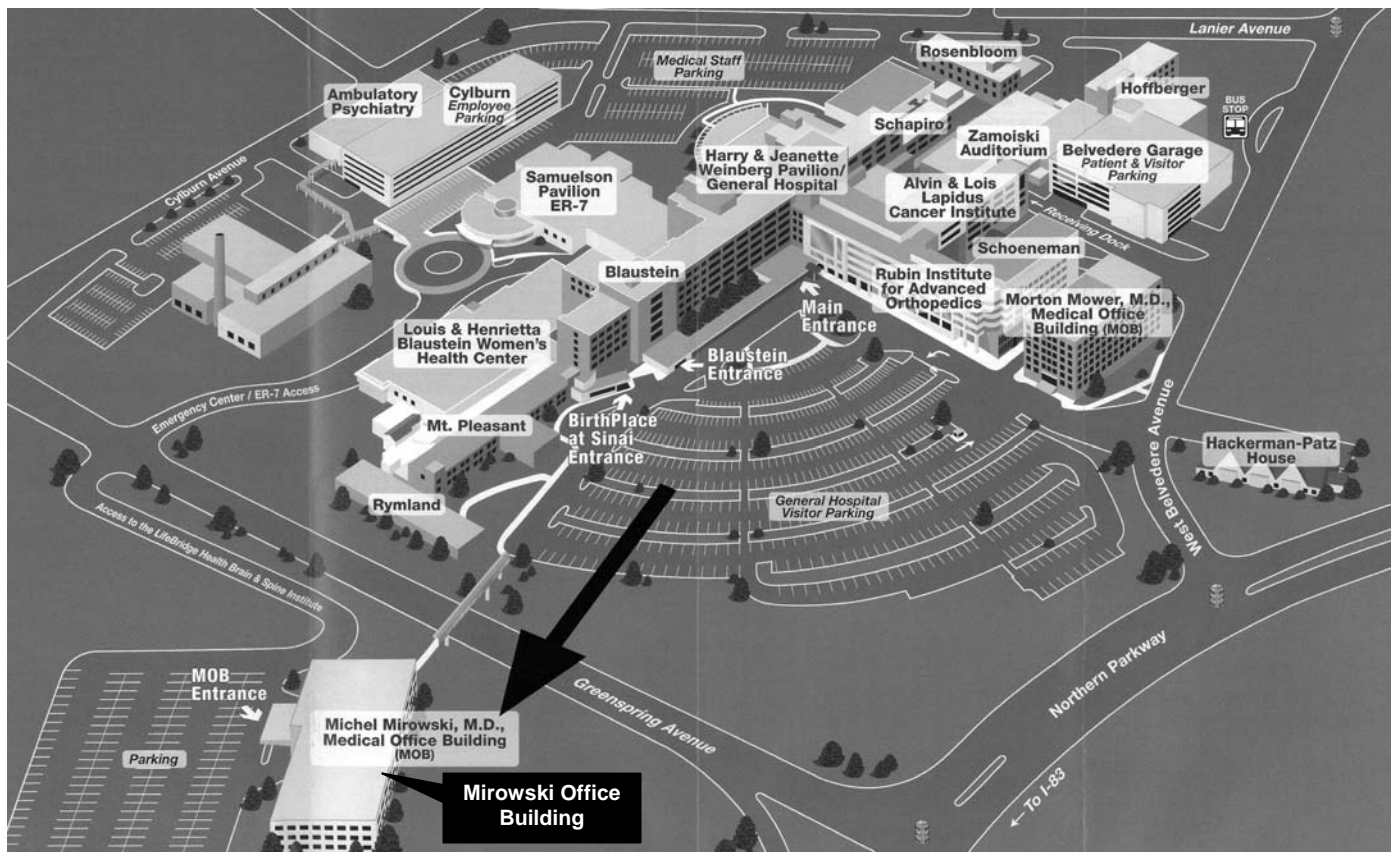
**From the East and Northeast** — From Towson, Harford County, and points farther north, take I-95 South to Exit 64, I-695 West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. Head west on Northern Parkway. **Look below for directions from Northern Parkway.**

**From the South** — From the DC, MD, VA area, take I-95 North into downtown Baltimore via the I-395 Exit. Turn RIGHT at W. Pratt Street. Turn LEFT at S. President Street, which becomes I-83N/Jones Falls Expressway. Take I-83 North approximately 6 miles to Exit 10B, Northern Parkway West. **Follow directions from Northern Pkwy.**

**DIRECTIONS FROM THE HOFFBERGER BUILDING TO THE MIROWSKI BUILDING** — From the Belvedere Garage turn right onto West Belvedere Avenue, turn right onto Northern Parkway. Turn right onto Greenspring Avenue. **Follow directions below after turn onto Greenspring Avenue.**

### DIRECTIONS FROM NORTHERN PARKWAY TO MIROWSKI BUILDING —

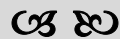
Proceed 0.6 miles up Northern Parkway and turn left at the stoplight onto Greenspring Avenue. Shortly after you pass under a footbridge across Greenspring Avenue, make the very first left into the driveway that leads up the hill to the parking lot. The driveway entrance is directly across from the Emergency Room (ER7) entrance and is marked by a blue sign pointing to the Mirowski Office Building and the Brain & Spine Institute.



You will be seen in the Michel Mirowski Medical Office Building.

Patient parking is located in front of the main entrance.

**The clinic is on the 2<sup>nd</sup> floor of 5051 Greenspring Avenue.**



Please help us to be respectful to all of our patients and to our physicians and arrive for your appointment at the registration time that appears on the front page of this packet.

If you do not arrive on time, **we may reschedule your appointment.**

- Please bring your insurance card and photo ID with you to every visit.
- If your insurance carrier requires a referral, please ensure that it is valid and that we have a copy of it prior to your visit. **It is your responsibility to obtain the referral and to follow through to ensure that we have received it.** If you do not have your referral at the time of your scheduled visit, **we may reschedule your test, or you will be responsible for your bill.** Please inform us before your appointment of any changes in your insurance coverage.

**NOTE:** ➤ WE CANNOT PERFORM AN EEG ON PEOPLE WITH **HAIR TRACKS, CERTAIN BRAID STYLES (NOT INCLUDING SINGLE BRAIDS), OR HAIR PIECES THAT ARE NOT REMOVABLE.** IF YOU HAVE ANY QUESTIONS, CALL **410-601-5709 AS SOON AS YOU RECEIVE THIS PACKET.**

- FOR YOUR APPOINTMENT, WEAR **BUTTONED OR ZIPPED CLOTHING THAT CAN BE REMOVED WITHOUT PULLING IT OVER YOUR HEAD.**

**To prepare for your EEG, follow these instructions:**

- **Do not drink caffeinated beverages for 12 hours prior to your procedure.**
- **Decrease the amount of time that you sleep the night before the EEG to half of the amount that you normally sleep.**
- **Take medications as prescribed.**
- **Eat meals as usual.**
- **Arrive with clean hair, free of all hair products (gel, mousse, hairspray, etc.).**
- **Wear buttoned or zipped clothing that can be removed without pulling it over your head.**

- If for any reason you cannot make your appointment, **call 410-601-9755 to cancel at least 72 hours prior to your appointment.**
- If you do not arrive for your scheduled appointment and have not canceled at least 24 hours in advance, **you will be charged a \$25 no-show fee.**
- Patients who miss 3 scheduled appointments and do not respond to our telephone calls or letters may be dismissed from our practice.

## **PARKING**

Our building does NOT have an ATM machine. Bring cash or credit card (Visa, Master Card, Discover—NOT American Express) to pay for parking (with validation, the parking fee is only \$3).

## **NECESSARY MEDICAL INFORMATION FOR YOUR VISIT**

Please have available for the physician the name, office address, and phone number of your referring physician and/or primary care provider so that we can communicate with him/her. Please bring a written list (on page 8 of this packet) of all of your current medications, including dose and frequency, or bring the medication bottles—**this is important for new and follow-up patients.**

If you have had any relevant testing (MRIs EEG, bloodwork, consultations/reports from other providers), please ensure that you bring copies of those reports with you. NOTE: We are not able to copy reports that you bring with you. Please come prepared with copies that you will leave with us.

**Do not assume that your primary care physician will send this information.**

## **MESSAGES/PHONE CALLS**

We attempt to return all phone calls within 24 hours. Sometimes, your call will be returned by another physician or by our physician assistant. If you are comfortable with e-mail, we would be happy to communicate with you by email. You can write to our physicians at **[bsiphysicians@lifebridgehealth.org](mailto:bsiphysicians@lifebridgehealth.org)**.

## **BILLING QUESTIONS**

Before your visit, we check to determine if your insurance is active and to obtain any authorizations that are required. However, **it is your responsibility to obtain any referral that may be required by your insurance company and to determine your financial responsibility for your visit**, including any amounts that will be charged against your deductible or co-insurance. If you require billing codes to determine your out-of-pocket expenses, we will be happy to provide them. **We must receive the request for this information a minimum of 5 business days prior to your appointment.**

Following your visit, you may receive two bills, one for physician services and one for hospital services.

For billing questions about your doctor's bills, please call 410-469-4369.

For questions about bills from Sinai Hospital relating to neurodiagnostic tests (EEG, EMG/NCS), call 410-601-1094 (800-788-6995 out of Baltimore area).

For questions about bills from Northwest Hospital, call 410-521-5959 (877-617-1803 out of Baltimore area).

We know that the payment and insurance process related to your visit may seem confusing. Do not hesitate to ask any staff member for clarification. We are here to ensure that your visit is productive, positive, and comforting.

Our staff is committed to providing quality care and customer service to all of our patients. Your safety and privacy are important to us, and we will do our utmost to safeguard them. If during your visit you have any questions or concerns, please do not hesitate to let us know. If at any time you are not satisfied with the handling or resolution of your concern, you may contact Guest Relations at 410-601-8778.

Thank you for your attention to our policies. We look forward to seeing you and will do our best to provide you with excellent care.



# Neurology New Patient Registration Sheet

The Sandra and Malcolm Berman  
Brain & Spine Institute

**Please complete these documents and bring them with you on the day of your appointment.**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ LANGUAGES: \_\_\_\_\_ RELIGION: \_\_\_\_\_

### ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE?  YES  NO

HAVE YOU NAMED A PERSON TO MAKE MEDICAL DECISIONS FOR YOU  
IF YOU ARE UNABLE TO MAKE THOSE DECISIONS FOR YOURSELF?  YES  NO

IF SO, WHO IS THAT PERSON? \_\_\_\_\_

### INSURANCE HOLDER INFORMATION and/or EMPLOYMENT INFORMATION:

**NAME OF INSURED IF OTHER THAN PATIENT:** \_\_\_\_\_

SSN: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DOB: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

**NAME OF INSURANCE:** \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_ RETIREMENT DATE: \_\_\_\_\_

INSURANCE ID NUMBER: \_\_\_\_\_

~ PLEASE COMPLETE OTHER SIDE ~

The information furnished above will be used ONLY for billing and accounting purposes.

*Please complete these documents and bring them with you on the day of your appointment.*

PATIENT NAME \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

WORK NUMBER: \_\_\_\_\_ HOME NUMBER: \_\_\_\_\_

**REFERRING PHYSICIAN**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

**PHARMACY**

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

**The information furnished above will be used ONLY for billing and accounting purposes.**

## Authorization and Assignment of Insurance Benefits

PATIENT NAME \_\_\_\_\_

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees to the following:

1. I authorize payment of medical benefits to the physician(s) rendering service(s).
  2. I agree and acknowledge that my signature on this document authorizes my physician(s) to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on every claim submitted for me and/or my dependent(s). I will be bound by this signature as though the undersigned had personally signed the particular claim.
  3. I will pay to the physician(s) any balance due for services rendered. I understand that if payment is not made on my behalf (by my insurer, legal representative, or workers compensation insurance), I will be responsible for any outstanding balance.
  4. I understand that the Sinai Department of Neurology checked with my insurance company prior to this visit to determine whether my insurance is active and to obtain any required authorizations.
  5. If I have received neurodiagnostic testing, I understand that following my visit, I will receive two bills—one for the doctor's services and one for the hospital's services.
  6. I understand that it is my responsibility to obtain any referrals required by my insurance company and to determine my financial responsibility for all charges for this visit, including those from the doctor and from the hospital and any amounts that will be charged against my deductible or co-insurance.
- The reason for this visit **is not** the result of a motor vehicle accident and is not covered by my automobile insurance.
- The reason for this visit **is** the result of a motor vehicle accident, and the claim for services provided should be submitted to my insurance carrier:

\_\_\_\_\_  
*insurance company*

\_\_\_\_\_  
*claim number*

\_\_\_\_\_  
*adjuster's phone number*

- The reason for this visit **is not** the result of a Workers Compensation claim and, therefore, payment for this visit **is not** eligible for payment by Workers Compensation insurance.
- The reason for this visit **is** the result of a Workers Compensation claim, and the claim for services provided should be submitted to my Workers Compensation carrier:

\_\_\_\_\_  
*Workers Compensation carrier*

\_\_\_\_\_  
*claim number*

\_\_\_\_\_  
*adjuster's phone number*

**I UNDERSTAND THAT IF I HAVE NOT PROVIDED CORRECT AND TRUTHFUL INFORMATION REGARDING THE REASON FOR THIS VISIT AND INSURANCE COVERAGE, I WILL BE RESPONSIBLE FOR ANY UNPAID CLAIMS.**

\_\_\_\_\_  
*signature of patient, parent/guardian, guarantor*

\_\_\_\_\_  
*date*







PATIENT NAME \_\_\_\_\_

**Medications**—Current

*(Please include over-the-counter medications, e.g., aspirin, Aleve, Advil, herbs, and vitamins.)*

	<u>Dosage</u>	<u>Times per day</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____

**Medications**—Previous: *(Medications used in the **past** for your current problem.)*

<u>Name of Medication</u>	<u>Dosage</u>	<u>Name of Medication</u>	<u>Dosage</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

**Medication Allergies:**

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***Please complete these documents and bring them with you on the day of your appointment.***