

Welcome!

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

You are scheduled for an appointment with:

Dr. _____ for an EMG/Nerve Conduction Study.

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 2nd floor of 5051 Greenspring Ave.

- ➔ You will receive an automated reminder call 48 hours prior to your appointment.
- ➔ Someone from our office will call you the day before your appointment to remind you.

Things You Must Know or Do

1. Read the pages of this packet and the EMG brochure for **IMPORTANT INSTRUCTIONS**.
2. Complete and sign the forms on pages 5–12 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 do so**.
4. If you do not arrive in sufficient time to allow for registration or if you do not bring a required referral, **your appointment may be rescheduled**.
5. Our building does NOT have an ATM machine. Please bring cash, check, or credit card (Visa, Master Card, or Discover—NOT American Express) for your co-pay and cash or credit card for parking (with our validation, the parking fee is only \$3).
6. To print more copies of this packet, go to www.lifebridgehealth.org/NeurologyAppointments.

Things You Must Bring

1. Insurance card (every visit)
2. Photo ID (every visit)
3. Referral, if necessary, and/or authorization from requesting physician.
4. Completed and signed pages of this packet—pages 5–12.
5. A list of current medications (page 12 of this packet) or bring your medication bottles.

If you have any questions, contact us at **410-601-9755** or **bsiphysicians@lifebridgehealth.org**.

We appreciate your choosing LifeBridge Health and look forward to participating in your healthcare.

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 2nd 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.**

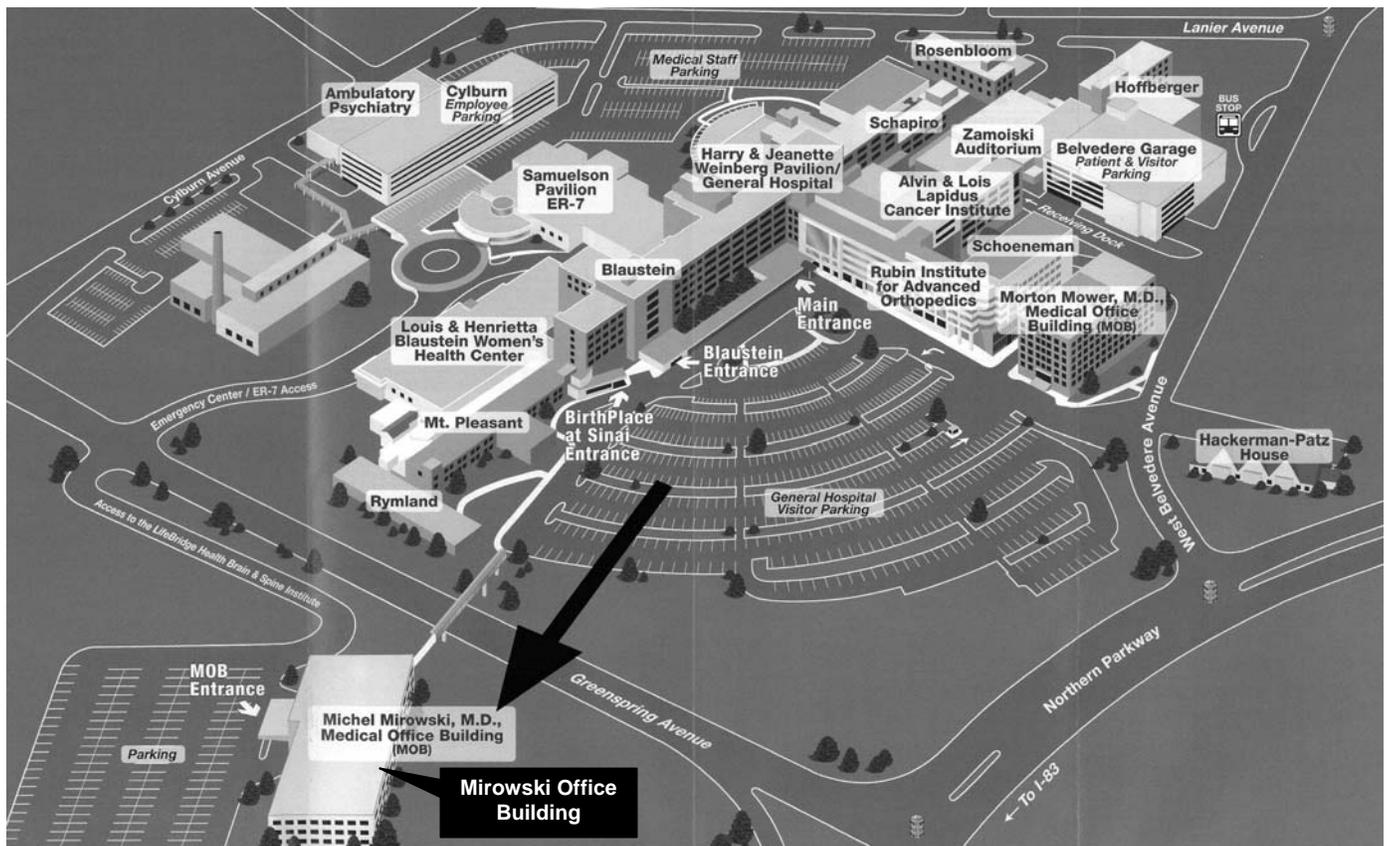
From the East and Northeast — From Towson, Harford County, and points farther north, take I-95 South to Exit 64, I-695 West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. Head west on 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.
The clinic is on the 2nd floor of 5051 Greenspring Avenue.
Patient parking is located in front of the main entrance.***

*Please help us to be respectful to all of our patients and to our physicians.
On the first page of this packet, you were given an appointment time
and a registration time. For example,*

if your appointment is scheduled for 8 am, we expect you to arrive
15 minutes prior to your appointment time.

if your appointment is scheduled for any other time, we expect you to arrive
30 minutes prior to your appointment time.

If you do not arrive at these intervals before the scheduled time,
we may reschedule your appointment.

THINGS THAT YOU MUST DO TO PREPARE FOR YOUR EMG

1. If you have an AICD, contact Jacquie at 401-601-9755, as soon as you receive this packet so that we can arrange for a representative from the device company to be present during the study.
2. Bring cardiac card, if applicable, for electronic devices such as pacemakers and AICDs (defibrillators).
3. Bring prior studies, either actual film or on CD (MRI/CT/x-ray).
4. On the day of the study
 - Take all medications as prescribed, **WITH TWO EXCEPTIONS:**
 - DO NOT use any pain-killing creams or patches for at least 12 hours before the test.
 - If you have myasthenia gravis, ask your EMG doctor if you should take any medications before the test.
 - Take a bath or shower to remove oil from your skin.
 - Do not use any lotions or gels on your skin
 - Wear loose-fitting clothing

If your insurance requires a referral, please ensure that the referral 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 IT. If you do not have your referral at the time of your scheduled visit, we may need to reschedule your appointment. Please inform us before your appointment of any changes in your insurance coverage.

PARKING

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

If for any reason you cannot make your appointment,
please call 410-601-9755 to cancel at least 72 hours prior to your appointment.

If you do not arrive for your scheduled appointment and you have not canceled at least 24 hours in advance, you will be charged a \$25 no-show fee.

NECESSARY MEDICAL INFORMATION FOR YOUR VISIT

Please have available for your appointment the name, office address, and phone number of your referring physician and/or primary care provider so that we can communicate with him or her. Please bring a written list (on page 12 of this packet) of all medications that you currently take, 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 those reports and/or films with you.

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 a 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.

PRESCRIPTION REFILLS

For refills, your pharmacy must fax a refill authorization request to us at **410-601-8905**. If we have no questions, we will refill your prescription. All refill requests will be completed within 2 business days of receipt, and you should follow-up with your pharmacy to check on the refill.

Please do not wait until the last minute to contact your pharmacy to request a refill.

If your pharmacy advises you of problems with the refill, call 410-601-9515, press #3, and leave a complete message. We will resolve any issues within 2 business days.

IF YOU EXPERIENCE PROBLEMS WITH YOUR MEDICATION AND NEED EMERGENCY CARE, CALL 911.

If you experience problems with your medication but do not need emergency care, call 410-601-9515, press #3, and leave a complete message.

DO NOT call this phone line for automatic refill requests.

NOTE: If you have not been seen by one of our healthcare providers within the last year, we will not write a prescription for you until you have been seen in our clinic.

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,
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 the insurance process related to your visit may seem confusing. Please 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.



The Sandra and Malcolm Berman
Brain & Spine Institute

Neurology New Patient Registration Sheet

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? YES NO

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? 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.

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*

Name: _____ Date: _____

Briefly describe the problem:

Onset: 0–1 mos 1–3 mos 3–6 mos >6 mos

Testing for problem: EMG MRI CT scan Other _____
(Please bring films and reports.)

Medical Problems

	Yes	No		Yes	No
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	6. Head trauma/injury	<input type="checkbox"/>	<input type="checkbox"/>
2. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart disease/attack	<input type="checkbox"/>	<input type="checkbox"/>	8. Surgical Issues/Operations: _____		
4. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____		
5. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
6. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	9. Other: _____		

Family History of similar condition or other neuromuscular disease? Yes No

If so, what _____

Review of Systems

	Yes	No
Change in bowel/bladder?	<input type="checkbox"/>	<input type="checkbox"/>
Change in gait (walking)?	<input type="checkbox"/>	<input type="checkbox"/>
Rash?	<input type="checkbox"/>	<input type="checkbox"/>
Recent bruising?	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Tobacco No Yes (amount) _____ How many years? _____

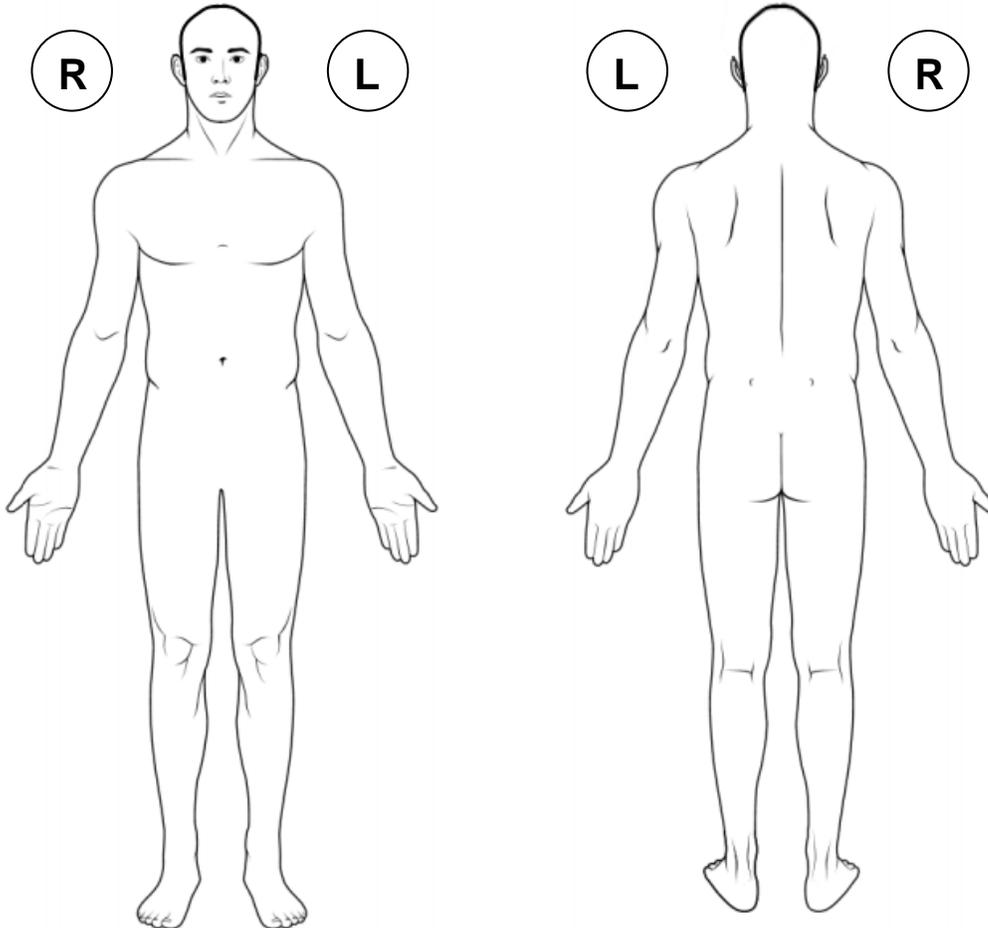
Alcohol No (only social) Yes _____ How many years? _____

Occupation

Past: _____ Present: _____

Patient Name _____

Please shade in any areas of numbness (N), pain (P), and/or weakness (W), and write "N", "P", or "W".



PRESENT MEDICAL HISTORY

- Are you taking coumadin or any other blood-thinning medication? NO YES
- Do you have a pacemaker/defibrillator? NO YES
- Are you allergic to latex or tape? NO YES

Please list any allergies that you have.

Patient's signature

Physician's signature

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:

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