

This welcome packet is for _____

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

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

on _____, _____, 20 _____ at _____
day of the week month and day

am
 pm

➔ You are expected to arrive at your registration time _____

am
 pm

➔ We will call you 2 days before your appointment to remind you.

Things You Must Know or Do

1. Read the pages of this packet:
 - a. Directions and map
 - b. **Important instructions**
 - c. The forms in this packet must be completed and signed **before** your visit and brought with you when you come (**do not mail them**).
2. To print out more copies of this packet, go to www.lifebridgehealth.org/NeurologyAppointments.
3. Minors **must be** accompanied by an authorized adult.
4. If you do not arrive in time to allow for registration or if you do not bring a required referral, **your appointment may be rescheduled.**
5. If your insurance company requires you to obtain a referral, **it is your responsibility to do so.**
6. 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.**
7. For your appointment, **(1) wear buttoned or zipped clothing that does not need to be removed by pulling over your head and (2) do not apply any lotions or gels to your skin.**

Things You Must Bring

1. Insurance card
2. Photo ID
3. Referral, if necessary, from requesting physician
4. A list of current medications (last page of this packet) or bring your medication bottles

If you have any questions, contact us at **410-601-9755**.

We look forward to caring for you.

**Directions to the Neurodiagnostic Suite • Sinai Hospital of Baltimore
2401 West Belvedere Avenue • Baltimore MD 21215**

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 10, 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 10, Northern Parkway. **Look below for directions from Northern Pkwy.**

From the West — From Howard County and points west, head east on I-70 or I-40 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 10, Northern Parkway. **Look below for directions from Northern Pkwy.**

From the East and Northeast — From Towson, Harford County, and points further 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 10, Northern Parkway.

Directions from Northern Parkway to Sinai Hospital — Head west on Northern Parkway. At the second traffic signal, turn left onto West Belvedere Avenue. Sinai Hospital will be on your left. Park in the parking lot and enter through the entrance to the Main Hospital. See "Upon Entering the Hospital" at bottom of this page.

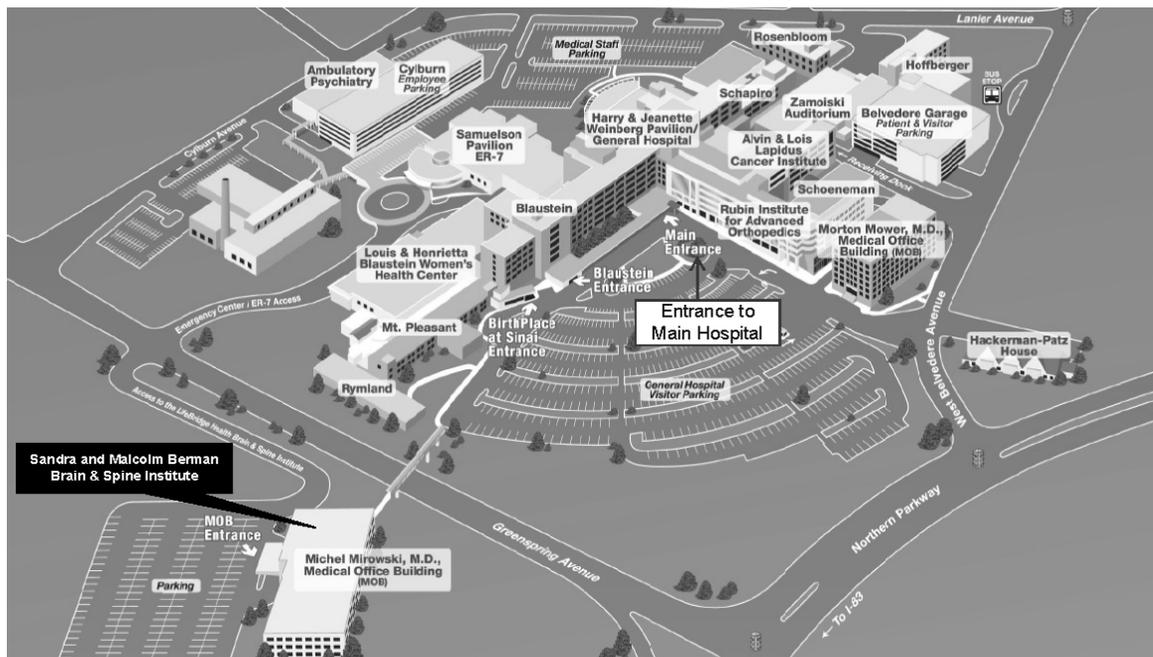
From the South — From the DC, MD, VA area, take I-95 North into downtown Baltimore via the I-395 Exit. Turn RIGHT at W. Pratt Street. Turn LEFT at S. President Street, which becomes I-83 North (Jones Falls Expressway). Take I-83 North to Exit 10B, Northern Parkway West. At the third traffic signal, turn left onto West Belvedere Avenue. Sinai Hospital will be on your left. Park in the parking lot and enter through the entrance to the Main Hospital. See "Upon Entering the Hospital" at bottom of this page.

Parking — At the time of the printing of this packet, parking charges at Sinai are as follows:

0–1/2 hr = \$0.00 • 1/2–2 hrs = \$4.00 • 2–3 hrs = \$5.00 • 3–7 hrs = \$6.00 • Over 7 hrs = \$10.00

Entering the Hospital

1. Enter the hospital through the main entrance and proceed through Covid screening.
2. Look ahead & to the right for a glass-enclosed office and for the sign that says "Patient Registration."
3. After registering, you will be instructed to have a seat in the main lobby to await a neurodiagnostic technician, who will come to escort you to the 5th floor Neurodiagnostic Suite.



Your testing will be performed at

**The Neurodiagnostic Suite, Sinai Hospital of Baltimore
2401 W. Belvedere Avenue, Baltimore MD 21215**

Please see detailed directions on second page of this packet.

Please help us to be respectful to all of our patients and to our physicians and arrive for your appointment at the time written 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 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 it.** If you do not have your referral at the time of your 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.

To prepare for your EEG, follow these instructions:

- **Do not drink caffeinated beverages for 12 hours prior to your procedure.**
- **Do not have any lotions or gels on your skin.**
- **Arrive with clean hair, free of all hair products (gel, mousse, hairspray, etc.).**
- **Take medications as prescribed.**
- **Eat meals as usual.**
- **For prolonged (4-hour) EEGs ONLY:**
Decrease the amount of time that you sleep the night before the EEG to half of the amount that you normally sleep. (Stay up late and get up early.)

NOTE:

- WE CANNOT PERFORM AN EEG ON ANYONE 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 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.**

- 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.

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 of all medications (page 10 of this packet) 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 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.

NO-SHOW POLICY

After patients miss their first and second appointments without letting us know, we write to remind them that our policy is that they must let us know at least 24 hours in advance if they are going to miss their appointments and that if they do not call at least 24 hours in advance, they will be charged a \$25 no-show fee.

If patients miss a third appointment without letting us know, we write to advise that we will no longer provide for their care, that we will be dismissing them from our practice, and that we will renew a needed prescription for only a 30-day supply, so that patients have time to find new providers.

MESSAGES/PHONE CALLS

We attempt to return all phone calls within 24 hours. Your call may be returned by one of our physicians or physician assistants.

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 will receive two bills, one for the doctor's services and one for the hospital's services. For billing questions about your doctor's bills, please call 410-517-8006. For hospital billing questions relating to any neurodiagnostic tests (EEG, EMG/NCS, or ENG), please call 410-601-6890; or, if you are outside the Baltimore metropolitan area, call toll free at 877-617-1803.

We know that the payment and the 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.

Authorization and Assignment of Insurance Benefits

Patient name _____ DOB _____
mm/dd/yyyy

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 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 or services from the Division of Adult & Pediatric Medical Psychology, 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 (mm/dd/yyyy)*



The Sandra and Malcolm Berman
Brain & Spine Institute

Patient Authorization

Patient name _____ DOB _____
mm/dd/yyyy

The providers in the Department of Neurology are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize the Department of Neurology to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Send me notices, clinical notes, and lab results via: text message email
4. I would like to receive an email invitation that provides instructions on how to register for the Sinai Hospital Patient Portal. yes no

_____ *please print email address*

5. Call my home or work and leave a message to contact the office.

My preferred method of contact for appointment reminders is

- home phone cell phone text message on cell phone email

_____ *home phone number*

_____ *cell phone number*

6. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
7. Update my personal demographic information either on the phone or in the office at the time of my appointment.
8. I give permission to discuss my personal health with the designated person(s) below:

_____ *name*

_____ *relationship*

_____ *name*

_____ *relationship*

I have read and agree to the above policies.

_____ *signature of patient*

_____ *date (mm/dd/yyyy)*

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.