LIFEBRIDGE HEALTH
The Sandra and Malcolm Berman Brain & Spine Institute

DEPARTMENT OF NEUROLOGY ~ ***Phone: 410-601-9755; fax: 410-601-8905***

- ❒ **Mirowski Medical Office Building,** 5051 Greenspring Avenue, #200, Baltimore MD 21209
- ❒ **LBH Medical Care Center,** 6190 Georgetown Boulevard, #2, Sykesville MD 21784
- ❒ **Quarry Lake,** 2700 Quarry Lake Drive, #360, Baltimore MD 21209

This 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 appointment with:

  Dr. _____for an EMG/Nerve Conduction Study.

- ➲ on_____, _____, 20 _____
  day of the week *month and day*

- ➲ **You are expected to arrive at** _____ ❒ am ❒ pm
- ➲ **You are expected to arrive at location checked above** (see enclosed directions).
- ➲ You will receive an automated reminder call 72 hours prior to your appointment.
- ➲ You will receive a call from someone in our office the day before your appointment.

Things You Must Know or Do

1. Read the pages of this packet and the EMG brochure for **IMPORTANT INSTRUCTIONS**.
2. Complete the forms in 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. Parking is free at the Quarry Lake office.
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, from requesting physician.
4. Completed pages of this packet.
5. A list of current medications (last page of this packet) or bring your medication bottles.

If you have any questions, contact us at **410-601-9515.**

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

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Important Information

The location of your test is checked at the top of the front page of this packet.

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.

If you do not arrive at the requested 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 (choose option #2), 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.

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 least24 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 (see page12of 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.

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 or EMG/NCS), 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.

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DEPARTMENT OF NEUROLOGY
New Patient Registration Sheet

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

Patient name:_____ Date: _____ *mm/dd/yyyy*

Social security #: _____ DOB: _____ *mm/dd/yyyy* Sex:_____

Address: _____

City, state, zip _____

Home phone: _____ Work phone: _____

Cellphone:_____ 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 them for yourself?

❒ Yes ❒ No If so, who is that person? _____

INSURANCE HOLDER EMPLOYMENT INFORMATION

Name of insured if other than patient: _____

SSN:_____ DOB_____ *mm/dd/yyyy* Relationship:_____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

City, state, zip: _____

Primary (main) insurance company: _____

Effective date: _____ Retirement date:_____ *mm/dd/yyyy*

Insurance ID number: _____

Secondary (supplemental) insurance company: _____

Effective date: _____ *mm/dd/yyyy* Retirement date:_____ *mm/dd/yyyy*

Insurance ID number: _____

~ continued ~

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 _____ DOB _____
mm/dd/yyyy

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.

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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)*

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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)*

MR7350-501-L

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Patient's Date of Birth _____

Patient's Street Address _____ Social Security Number _____

City, State, Zip Code _____ Phone Number _____

I, the undersigned, hereby authorize _____

☐ to **release** copies of medical records to: ☐ to **obtain** copies of medical records from:

☐ **Verbal** release only of medical information to:

Sinai Neurology-Neurodiagnostics — Name of Person or Agency

410-601-9755 — Phone Number

5051 Greenspring Avenue, Baltimore MD 21209 — Address, City, State, Zip Code

410-601-7828 — Fax Number

The purpose or need for such disclosure is _____

Dates of Service: _____

_____ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information.

- ☐ Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- ☐ Emergency Room Record
- ☐ Outpatient Surgery
- ☐ Discharge Summary
- ☐ Admission History and Physical
- ☐ Consultation Report
- ☐ HIV / AIDS Report
- ☐ Doctor's Office Notes
- ☐ Operative Report / Pathology Report
- ☐ Alcohol / Detox / Drug Abuse
- ☐ X-ray, EKG, EEG, Labs, Cardiopulmonary
- ☐ Physical Therapy / OT / Speech
- ☐ Nuclear Medicine
- ☐ Clinic
- ☐ Mental Health / Psychiatry
- ☐ Other _____

_____

Signature _____ **Date** _____ **Relationship to Patient** _____

Witness _____ **Date** _____

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) ***Photo Id** **may be requested at the time of release.**

MR# _____ Date Completed _____ Completed By _____ # pages _____

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EMG PATIENT QUESTIONNAIRE

Patient name: _____ **Date:** _____
mm/dd/yyyy

Briefly describe the problem:

_____

_____

_____

Onset: _____ days ago _____ months ago _____ years ago

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

Medical Problems	**Yes**	**No**		**Yes**	**No**
Diabetes	❒	❒	Head trauma/injury	❒	❒
Hypertension/high blood pressure	❒	❒	Headaches	❒	❒
Heart disease/attack	❒	❒	Stroke	❒	❒
Arthritis	❒	❒			

Surgical issues/operations: _____

_____

Other: _____

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

If so, what _____

Review of Systems	**Yes**	**No**		**Yes**	**No**
Change in bowel/bladder	❒	❒	Recent bruising	❒	❒
Change in gait (walking)	❒	❒	Shortness of breath	❒	❒
Rash	❒	❒	Fever	❒	❒

Social History

Current smoker ❒ No ❒ Yes (amount) _____ How many years? _____

Past history of tobacco use ❒ No ❒ Yes (amount) _____ How many years? _____

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

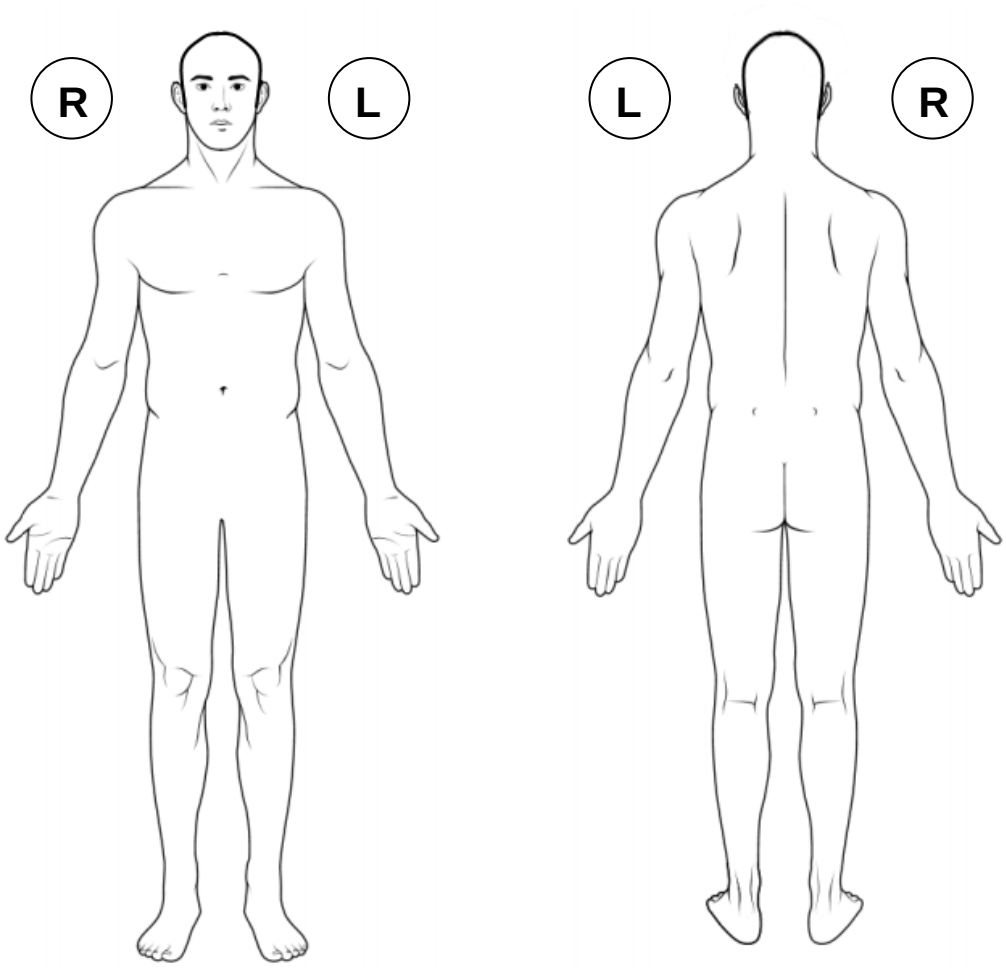
Drug use ❒ No ❒ Yes (type) _____ How many years? _____

Exercise (type) _____ How often? _____

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.

_____

_____
signature of patient

_____
signature of physician

Patient name _____

Medications—Current

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

		Dosage	Times per day
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.***)

	Name of Medication	Dosage	Name of Medication	Dosage
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.