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 ______

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.

06/08/21
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**:
     o DO NOT use any pain-killing creams or patches for at least 12 hours before the test.
     o 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 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 (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.
Please complete these documents and bring them with you on the day of your appointment.

Patient name: ____________________________________________ Date: ____________________________________________

Social security #: _____________________________________ DOB: ___________ 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 ___________________________ Relationship: ____________________________

Employer: ___________________________ Occupation: ____________________________

Address: ___________________________ Phone: ____________________________

City, state, zip: ____________________________

Primary (main) insurance company: ____________________________________________

Effective date: ___________________________ Retirement date: ____________________________

Insurance ID number: ____________________________________________________________

Secondary (supplemental) insurance company: ____________________________________________

Effective date: ___________________________ Retirement date: ____________________________

Insurance ID number: ____________________________________________________________
Neurology New Patient Registration Sheet

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 ________________

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: ________________________________

Registration (06/08/21)
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 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)
# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Patient's Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Street Address</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

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-Neriodiagnostics**

<table>
<thead>
<tr>
<th>Name of Person or Agency</th>
<th>410-601-9755</th>
</tr>
</thead>
<tbody>
<tr>
<td>5051 Greenspring Avenue, Baltimore MD 21209</td>
<td>410-601-7828</td>
</tr>
</tbody>
</table>

Phone Number

Address

Fax Number

City, State, Zip Code

The purpose or need for such disclosure is __________________________

Dates of Service: __________________________

[ ] Abstract (Summary, Op Report, Paths, Consults, H&P, lab work) [ ] Alcohol / Detox / Drug Abuse

[ ] Emergency Room Record [ ] X-ray, EKG, EEG, Labs, Cardiopulmonary

[ ] Outpatient Surgery [ ] Physical Therapy / OT / Speech

[ ] Discharge Summary [ ] Nuclear Medicine

[ ] Admission History and Physical [ ] Clinic

[ ] Consultation Report [ ] Mental Health / Psychiatry

[ ] HIV / AIDS Report [ ] Other

[ ] Doctor's Office Notes

[ ] Operative Report / Pathology Report

**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.*

<table>
<thead>
<tr>
<th>MR#</th>
<th>Date Completed</th>
<th>Completed By</th>
<th># of pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR7350-501-L (12/05)</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EMG PATIENT QUESTIONNAIRE

Patient name: ________________________________ Date: __________

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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Head trauma/injury</td>
<td></td>
</tr>
<tr>
<td>Hypertension/high blood pressure</td>
<td></td>
<td></td>
<td>Headaches</td>
<td></td>
</tr>
<tr>
<td>Heart disease/attack</td>
<td></td>
<td></td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Surgical issues/operations:

________________________________________________________________

Other: ___________________________________________________________

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

If so, what ______________________________________________________

Review of Systems

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in bowel/bladder</td>
<td></td>
<td></td>
<td>Recent bruising</td>
<td></td>
</tr>
<tr>
<td>Change in gait (walking)</td>
<td></td>
<td></td>
<td>Shortness of breath</td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td>Fever</td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________
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.)*

<table>
<thead>
<tr>
<th>Number</th>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Name of Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

**Medication Allergies**


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