

Neurodiagnostic Laboratories

EEG Data Sheet

Patient: _____ **Test Date:** _____

DOB: _____ **Age at time of test:** _____ **Gender:** --

Handedness: --

Previous EEG: --

Reason for Test: _____

Symptoms (if you are experiencing seizures, please explain):

Medications: _____

State of Consciousness: _____ **Sedation during test:** Y/N

HV performed: Y/N _____

PS performed: Y/N _____

Alpha: _____ **Beta:** _____

Theta: _____ **Delta:** _____

Tech Comments: _____

Referring Physician: _____ **Date:** _____

Ambulatory Electroencephalography Consent Form

I, _____, agree to undergo ambulatory electroencephalography (EEG) testing, which my physician has requested to further understand my medical condition.

I understand that EEG testing involves the placement of recording electrodes over the scalp and it will be recording the brain activity for at least 24 hours. There are no known side effects of this procedure as its purpose is to measure and record and is not used to provide therapy or treatment.

I will follow the technologist's instructions for use of the equipment. I understand that I am responsible for any damage or loss to the equipment and that I may be responsible for replacing the unit if it cannot be repaired. The cost to replace the equipment is \$8,375.

I have been properly informed of the risks, complications, consequences, and benefits as well as acknowledge that no guarantees regarding ambulatory EEG have been made. The alternative to ambulatory EEG testing is to not have it performed, in which case information regarding central nervous system disorders will not be specifically obtained.

My questions regarding ambulatory EEG have been answered and I acknowledge the above information and desire to proceed with the test.

Patient's Signature

Date

Physician/Witness Signature

FINANCIAL POLICY

Benefits are determined once a claim is received by your insurance company. Our facility will provide the service of billing your medical insurance company; however, as the patient and/or responsible party, you are responsible for providing us with **ALL** the **CORRECT** and **COMPLETE** information regarding medical insurance coverage at the time of service. It is also the responsibility of the patient and/or responsible party to pay for all co-payments, deductibles, and/or co-insurance amounts, if required by your insurance policy. If the insurance company denies the claim for services rendered due to reasons for which we cannot appeal, you understand that the balance will then become your responsibility.

As a cash paying patient, you are aware that half of the payment for services rendered are due at the time of service and payment arrangements may be made for the remaining balance.

A non-sufficient funds (NSF) fee of \$25 will be applied to any returned check and then we will only accept cash, credit card, or money order for any and all payments thereafter.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to AMDx, LTD/Neurodiagnostic Laboratories, LLC and or/it's affiliated entities or otherwise at its direction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by AMDx, LTD/Neurodiagnostic Laboratories, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by AMDx, LTD/Neurodiagnostic Laboratories, LLC.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY,
ASSIGNMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE
INFORMATION

Print Patient/Responsible Party Name: _____

Date Of Birth: _____

Social Security Number: _____

Patient/Responsible Party Signature: _____

Date: _____



PATIENT INFORMATION
NeuroDiagnostic
Laboratories

Please Print

Today's Date _____

Name _____ Date of Birth _____ Age _____
First Middle Last

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone() _____ Ext _____

Cell Phone () _____ E-mail _____

In case of emergency, name & phone number of nearest relative _____ () _____

Drivers License # and State _____ SS# _____ - _____ - _____

Sex: Male Female Marital Status: S M D W Name of Spouse _____

Primary Care Physician's Name _____ Phone() _____

GUARANTOR INFORMATION – Must be completed (Patient &/or Responsible Party):

Responsible party / Guarantor Name _____ Guarantor Date of Birth ____/____/____

Employer Name _____ Occupation _____

Employer's Address _____ Phone() _____

City & State & Zip _____ SS# _____

WORKER'S COMPENSATION/AUTO ACCIDENT CLAIM: YES NO

Insurance Carrier _____ Carrier Address _____

Claim # _____ DOI: ____/____/____

Adjuster's Name _____ Adjuster's Phone() _____

INSURANCE INFORMATION: PRIMARY (A valid Insurance card is required in order to bill)

Insurance Carrier _____ Insurance Group Number _____

Guarantor on Policy _____ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer _____ Address _____

Insured's SS # _____ Insured's Date of Birth ____/____/____

Plan ID # _____ Plan Effective Date ____/____/____

Annual Deductible Amount \$ _____ Co-Pay Amount \$ _____ Has patient's deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other

INSURANCE INFORMATION: SECONDARY (A valid Insurance card is required in order to bill)

Insurance Carrier _____ Insurance Group Number _____

Guarantor on Policy _____ Relationship to Patient: Self Spouse Dependent Other

Insured's Employer _____ Address _____

Insured's SS # _____ Insured's Date of Birth ____/____/____

Plan ID # _____ Plan Effective Date ____/____/____

Annual Deductible Amount \$ _____ Co-Pay Amount \$ _____ Has **patient's** deductible been met for this year? Y N

Type of Plan: PPO EPO POS HMO Indemnity Other



Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of American Medical Diagnostics Ltd (AMDX)/NeuroDiagnostic Laboratories, LLC (NDL) Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in AMDX/NDL's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the AMDX/NDL Patient Privacy Officer as indicated on your Notice.

Patient Name (Printed): _____

If Patient Representative, Name (Printed): _____

If Patient Representative, Relationship to Patient (Printed): _____

Signature: _____

Date Notice Received: _____