Neurodiagnostic Laboratories

EEG Data Sheet

Patient:_______________________________ ___ **Test Date:**____________________________________

DOB:______________________________ **Age at time of test:**______________ **Sex: Male / Female**

Handedness: Right / Left **Previous EEG: Y / N**

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:_____________________

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

ELECTROENCEPHALOGRAPHY TESTING CONSENT FORM

I, ____, agree to undergo electroencephalography testing (EEG), 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 the recording of brain activity. I also understand I may be asked to breathe heavily and stare at a flashing light. There are no known side effects of this procedure as its purpose is to measure and record and not to provide therapy or treatment.

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

My questions regarding 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.

If you fail to pay any amount owed within the time allotted, your account will be sent to a collections agency and you understand that you will then owe the amount for services rendered plus any and all collection costs and attorneys fees.

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:__________________________

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: ____