

PLEASE COMPLETE AND SIGN THE FOLLOWING:

NeuroDiagnostic

Laboratories

6036 N. 19th Ave., Suite 405
Phoenix, AZ 85015

NeuroDiagnostic

Laboratories

1450 S. Dobson Rd., Suite A305
Mesa, AZ 85202

NeuroDiagnostic

Laboratories

6828 E. Brown Rd. Suite 100
Mesa, AZ 85207

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ REFERRING PHYSICIAN: _____ MD / DO / PA

ARE YOU EXPERIENCING?

(CIRCLE ALL THAT APPLY)

PAIN

NUMBNESS

TINGLING

WEAKNESS

BURNING SENSATIONS

ELECTRICAL TYPE PAIN

OTHER

HOW LONG HAVE YOU HAD SYMPTOMS?

___ WEEKS MONTHS YEARS

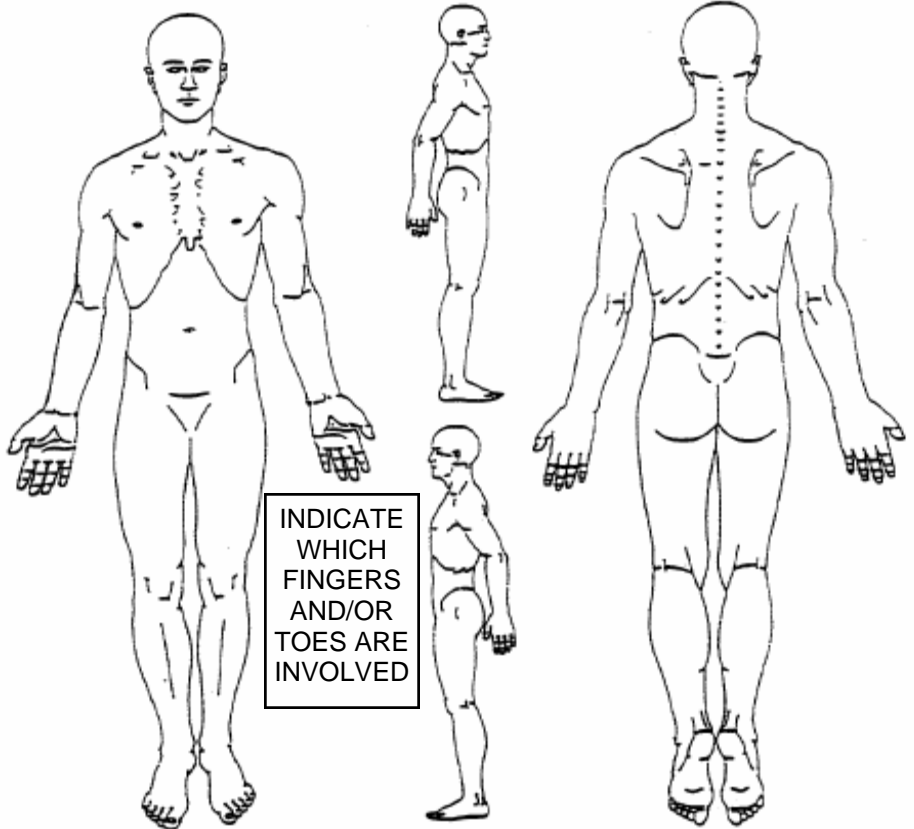
DO YOU HAVE:

DIABETES?

THYROID DISORDER?

BLEEDING DISORDER?

PLEASE INDICATE THE AREAS INVOLVING YOUR SYMPTOMS.



INDICATE WHICH FINGERS AND/OR TOES ARE INVOLVED

ARE YOU CURRENTLY TAKING ANY MEDICATION THAT MAY THIN YOUR BLOOD? YES NO

IF YES WHAT? (EXAMPLES: COUMADIN, ASPIRIN, OR ANTI-INFLAMMATORIES) _____

DO YOUR SYMPTOMS WAKE YOU OR PREVENT YOU FROM SLEEP? YES NO

WHAT MAKES YOUR SYMPTOMS WORSE? _____

WHAT MAKES THEM BETTER? _____

IS THERE ANY OTHER INFORMATION ABOUT YOUR SYMPTOMS THAT MAY BE HELPFUL?

(SURGERIES, ACCIDENTS, ILLNESSES, ETC.) _____

DO YOU HAVE ANY COMMUNICABLE DISEASES? _____

SIGNATURE OF PATIENT OR GUARDIAN: _____

Patient History Form

Last Name First Name Middle Date

Date of Birth Age Sex Are you Right or left handed?

What is the main reason you are seeing a neurologist? Describe onset. When did it start? What makes it worse or better, etc, etc...? _____

Medical History: List all medical conditions (e.g. diabetes, heart disease, high blood pressure, high cholesterol, arthritis, etc...) _____

LIST ALL SURGERIES AND DATES: _____

Any major accidents or injuries? _____

Any recent hospitalizations? (if yes, give details) _____

ANY ALLERGIES TO MEDICATIONS? Yes or No (if yes, list medication and reaction) _____

MEDICATIONS (List all medications with dosage and frequency you are currently taking? If needed, attach a separate page. _____

Have you had any of the following problems (check all that apply)? If yes, please explain.

Heart Disease		Neurologic (seizure, stroke, etc.)		Sexual Dysfunction	
High Blood Pressure		Abdominal (stomach/intestinal)		Psychological	
Lung Problems		Kidney or urinary problems		Nervous Breakdown	
Diabetes		Cancer (where and what treatment)		Ear, Nose, or Throat	

Please explain all yes answers, and describe other conditions:

Review of Symptoms: Do you have any of the following conditions or complaints? (Check all that apply)

Neurologic	Headache		Musculoskeletal	Muscle pain		
	Fainting/blacking out			Joint pain (if yes, where?)		
	Seizures			Psychiatric	Pain in any body part (if yes, where?)	
	Dizziness		Depression			
	Difficulty in speech		Anxiety			
	Memory problems more than age related		Bipolar Disorder			
	Muscle weakness		Infectious		Sexually transmitted disease	
	Numbness or tingling				HIV/AIDS	
	Difficulty walking				Hepatitis	
	Difficulty using hands			Tuberculosis		
Tremors			Scabies			
Constitutional	Fever			Other (please list)		
	Weight gain or loss		For Women	Menstrual problems		
	Sleep problems			Are you pregnant?		
	Fatigue			Are you planning on having children within the next year?		
Eyes	Double vision			Do you take birth control pills?		
	Blurred vision		Have you had a hysterectomy?			
	Eye pain		Other (Please list)			
	Other					
Ears, Nose, and Throat	Difficulty swallowing					
	Hearing loss					
	Hearing aids					
	Ringing in ears					
Cardiac	Ear pain					
	Chest pain		Social History:			
	Palpitations		Do you Smoke Regularly? ___ Yes ___ No			
	Heart murmur		Cigarettes___ Pipe___ Cigars ___			
Respiratory	Swelling in legs		How often per Day___			
	Shortness of breath		For How Long? ___ Days / Months / Years			
	Cough		Do You Drink Alcohol? ___ Regularly? ___ Yes ___ No ___			
Gastrointestinal	Asthma		Beer ___ Wine ___ Hard Liquor ___			
	Reflux/heart burn		How much Per Day? ___			
	Nausea		How Many Per Week? ___			
	Vomiting		Do you use any street drugs? ___ Yes ___ No			
	Constipation		Are you, or have you been addicted to any drugs or alcohol? ___ Yes ___ No			
	Diarrhea		Any blood transfusions? ___ Yes ___ No			
	Abdominal pain		Tattoos? ___ Yes ___ No			
Urologic	Bowel incontinence		Risky sexual activity for STDs? ___ Yes ___ No			
	Urinary hesitancy/dribbling		What is your current job? _____			
	If Male, Prostate Disorder?		If Retired, what did you do prior to retirement? _____			
	Kidney stones					
Endocrine	Pain during urination					
	Diabetes		What is your highest level of education? _____			
Hematologic	Thyroid Disorder					
	Anemia		Are you: Single / Married / Divorced / Widowed			
Easy bruising						
For Doctor's Use Only: Date _____						
Reviewed By: _____						

FAMILY HISTORY:

Are you Adopted? _____

Family History	If Alive is health good/fair/poor? And list any illnesses	Age	Cause of Death
Father			
Mother			
Siblings			
(List Individually)			
Children			
(List Individually)			

Any blood relative who has had the following (list each relative - e.g. Mother, paternal grandfather, etc):	
Similar type of illness that you currently have	
Stroke	
Alzheimer's or dementia	
Migraines	
Seizure disorder or epilepsy	
Muscle Disease	
Nerve Disease or neuropathy	
Tremor	
Parkinson's Disease	
Heart Disease	
High Blood Pressure	
Diabetes	
Cancer	
Blood Clotting Disorder	
Other	



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

Electrodiagnostic Testing Consent Form

I, _____, agree to undergo electrodiagnostic testing (EDX), which includes nerve conduction studies (NCS) and electromyography (EMG), because my physician has requested this test to further understand my medical condition.

I understand that NCS involves receiving very brief electrical impulses through the nerves to see if they are working correctly. This test may be uncomfortable and creates a twitching movement of the area being tested. No clear dangers have been found from this type of testing except in patients with cardiac pacemakers, or intravenous tubes, in which case this test may still be performed.

I understand the EMG consists of insertion of tiny needle-like electrodes into various muscles to see if there are any abnormalities. This test may be uncomfortable and on rare occasion, may result in minor bruising or bleeding at the site of insertion. There is a very rare possibility of infection. If I have a bleeding disorder or take blood-thinning medication, this test may not be performed.

I understand the risk, complications, consequences, and benefits, as well as acknowledge that no guarantees regarding EDX have been made. The alternative to EDX is to not have it performed, in which case information regarding damage to nerves and/or muscles will not be specifically obtained. There are no clear substitutes for this particular method of testing.

My questions regarding EDX testing have been answered. 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: _____