NeuroDiagnostic Laboratories

Patient Name: _____ **DOB**: _____ / _____ / _____ **AGE: _____**

HISTORY: PLEASE COMPLETE ALL SECTIONS BELOW

Have you ever had an Electroencephalography (EEG)? ☐ NO ☐ YES When? _____

Do you have a history of seizures? ☐ NO ☐ YES When? _____

Please select: ☐ RIGHT Handed ☐ LEFT Handed

What is the reason for testing today? _____

Please describe your symptoms: _____

_____

_____

MEDICATIONS: PLEASE LIST THE NAME(S) AND DOSAGE(S) OF ALL MEDICATIONS YOU CURRENTLY TAKE

Check here for ☐ ***NO Medications***

_____ _____ _____

_____ _____ _____

Known Allergies: _____

********** THIS SECTION IS FOR USE ONLY BY THE PERFORMING PHYSICAN OR TECHNICIAN **********

Patient's State of Consciousness: _____ Sedation Used? ☐ NO ☐ YES

HV Performed? ☐ NO ☐ YES _____ PS Performed? ☐ NO ☐ YES _____

Alpha: _____ Beta: _____ Theta: _____ Delta: _____

Physician/Technologist Comments:

_____

_____

_____

_____

NeuroDiagnostic Laboratories

Appointment DATE: _____ / _____ / _____

Patient Name: _____ **Date of Birth**: _____ /_____ / _____

Patient S.S. #: _____ - _____ - _____ **Gender**: **M / F** **Marital Status**: Single / Married / Divorced / Widow

Patient Address:_____ # _____

City: _____ **State**: _____ **Zip Code**: _____

Home ( ) _____ - _____ **Work** ( ) _____ - _____ **Cell** ( ) _____ - _____

In Case of Emergency Contact

***Name**: _____ **Relationship**: _____ Phone: ( ) _____ - _____

Primary Care Physician: _____ Phone: ( ) _____ - _____

Was a current insurance card presented for today's appointment? Y / N

If YES – no additional information is needed

If NO – please complete the fields below

Primary Insurance:

Carrier: _____ Group# _____ Plan ID: _____

Guarantor Name (if not self): _____ Relationship: _____

Guarantor Date of Birth: _____ / _____ / _____ SS# _____ - _____ - _____

Secondary Insurance:

Carrier: _____ Group# _____ Plan ID: _____

Guarantor Name (if not self): _____ Relationship: _____

Guarantor Date of Birth: _____ / _____ / _____ SS# _____ - _____ - _____

Worker's Comp: ☐ Y ☐ N Auto Accident: ☐ Y ☐ N Date of Injury: _____ / _____ / _____

W/C Office: _____ Claim #: _____

AMBULATORY ELECTROENCEPHALOGRAPHY (AEEG) TESTING CONSENT

Ambulatory Electroencephalography (AEEG) testing involves the placement of multiple electrodes over the scalp to make a recording of brain activity for no less than twenty-four (24) hours up to and including seventy-two (72) hours.

AEEG testing is performed only as a method to measure and record brain activity and is not a form of therapy or treatment. There are no known side effects for this method of testing. There are no guarantees regarding the results of AEEG testing. There are no clear substitutes for this particular method of testing. The alternative to an AEEG is to refuse testing, in which case any information regarding potential central nervous system disorders will not be obtained.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE PROCEDURES THE DEFINITIONS FOR AEEG TESTING, AS OUTLINED WITHIN THIS DOCUMENT.

□ I agree to undergo the AEEG testing as my physician has ordered to further understand my medical condition. Additionally, I agree to follow the instructions provided by the technologists, as well as those outlined in the AEEG Guidelines for Utilization. I understand that I am financially responsible for any/all damage to, or loss of the AEEG equipment. In event that the damage is beyond reasonable repair, I am responsible for the cost to replace the equipment, which is no less than the current market value (approximately, $10,000.00).

□ I refuse to undergo the AEEG testing, even though my physician has ordered it to further understand my medical condition.

Patient Name: _____ **Patient Signature**: _____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____ Representative Signature: _____

NeuroDiagnostic Laboratories

FINANCIAL POLICY

As a courtesy to our patients, our facility will provide the service of billing your insurance carrier. However, practical benefits are not determined until a claim is received by your insurance company. When requested, our group can provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, an initial payment equal to no less than one half (1/2) of the total cost for the ordered test(s) is due at the time service is rendered. Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. / Neurodiagnostic Laboratories, LLC (NDL, LLC).

A Non-sufficient Funds (NSF) Fee of $25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd. / NDL, LLC and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment(s) and coverage for services and/or supplies provided to me by AMDx, Ltd. / NDL, LLC.

AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF

I further authorize AMDx Ltd. / NDL, LLC and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare if I am a Medicare beneficiary. I understand that in the event of an adverse decision made by my insurance carrier(s) as it relates to coverage, authorization or payment(s), AMDx Ltd. / NDL, LLC is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

Patient Signature: _____ **Date**: _____

Patient Name (printed): _____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____ Representative Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practice And Patient Rights Form

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories, LLC (AMDx) Notice of Privacy Practices and Patient Rights Form. AMDx maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein.

Any questions you have regarding the information provided in the AMDx Notice of Privacy Practices or Patient Rights Forms should be directed to AMDx Administrative staff or the Privacy Officer indicated on the Privacy Practice.

I understand that certain disclosures are required under federal law and may be released by AMDx, upon request from an authorized entity, as outlined below:

- Public Health Activities
- Health Oversight Activities
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Certain research projects
- Disclosures necessary to prevent serious threats to health or safety
- Military Command Authorities; if you are a member of the armed forces or foreign military authority
- National Security and Intelligence
- Worker's Compensation Payers; and
- Disclosures necessary to initiate and complete health care treatment
- Payment and operations or functions by business associates

I further understand that the disclosures outlined below may be considered optional and that I may choose to 'opt out' of these types of disclosures by selecting '*decline'* for any or all circumstances below.

- Family members or close friends who are involved in your care or payment for treatment ☐ DECLINE
- Disaster Relief Agencies; if you are involved in a disaster relief effort; and ☐ DECLINE
- Information provided to you regarding alternative treatments for your health care ☐ DECLINE

I have been given, and have read and understand my rights under the Notice of Privacy Practices.
I have been given, and have read and understand my rights under the Patient Rights Form.

Patient Signature: _____ **Date**: _____

Patient Name (printed): _____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____ Representative Signature: _____

Patient Rights

As an individual receiving services through NeuroDiagnostic Labs, you have the right:

- To receive services regardless of your race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- To receive services that support and respect the patient's individuality, choices, strengths, and abilities.
- To receive privacy in care for personal needs.
- To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- To receive a referral to another health care institution if the provider is unable to provide physical health services or behavioral health services for the patient.
- To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
- To be treated with consideration, respect and dignity, including privacy in treatment.
- To not subjected to: Abuse; Neglect; Exploitation; Coercion; Manipulation; Sexual abuse; Sexual assault; Seclusion; Restraint, if not necessary to prevent imminent harm to self or others; Retaliation for submitting a complaint to the Department or another entity; or Misappropriation of personal and private property by a unclassified health care institution's personnel members, employees, volunteers, or students; and A patient or the patient's representative
- To be information of the patient compliant process.
- To be given the opportunity to give consent to photographs of the patient before a patient is photographed except that a patient may be photographed when admitted to a health care institution for identification and administrative purposes.
- To provide written consent to the release of patient's medical records and financial records.
- To express complaints about the care and services provided and to have the health center investigate such complaints. NeuroDiagnostic Labs is responsible for providing you or your designee with a written response within 30 days, if requested, indicating the findings of the investigation. NeuroDiagnostic Labs is also responsible for notifying you or your designee that if you are not satisfied by our response, you may complain to the Arizona Department of Health Office.

Submit complaints in writing to:

NeuroDiagnostic Labs
Attn: Mike McCloskey
2423 W. Dunlap Ave #175
Phoenix, AZ 85021

NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS INTENDED TO DESCRIBE HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION

** PLEASE REVIEW THIS INFORMATION CAREFULLY **

1) **PURPOSE:** American Medical Diagnostics, Ltd (AMDx, Ltd.), NeuroDiagnostic Laboratories, LLC (NDL) and their employees follow the privacy practices described within this notice. AMDx, Ltd. / NDL maintain your health information and confidential records, as required by law. AMDx, Ltd./ NDL may use, disclose or share your health information as pertains to your treatment, payment of services and the general healthcare operations, necessary to provide you with quality health care.

2) **WHAT ARE TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS? Treatment** may include sharing information with the other health care providers who are involved in your care. For example, your health care provider may need to share information about your condition with a pharmacist in order for you to receive medications. **Payment** may include use of your health information as required by your insurance carrier to obtain prior authorization, when applicable, and payment for services rendered. **Health Care Operations** may include limited use of your health information to help improve the quality of your care and/or for educational purposes as it relates to the training of AMDx, Ltd. / NDL employees and staff.

3) **HOW WILL AMDx, Ltd. /NDL USE OR DISCLOSE MY HEALTH INFORMATION?** Your health information may be used for the following reasons or disclosed to the following individuals and entities. *Note: You may refuse any/all communications outlined below, when shown with an asterisk (*)*.

- Family members or close friends who are involved in your care or payment for treatment, or to family members, a personal representative or another person responsible for your or regarding your location, general condition or death. (*)
- Disaster Relief Agency, if you are involved in a disaster relief effort (*)
- Information provided to you, regarding alternative treatments or services related to your health (*)
- Appointment Reminders
- Public Health Activities, such as; disease prevention, injury or disability, reporting of births/deaths, reporting adverse reactions to medications or product concerns, notification of recalls, infectious disease control, and notification to government agencies for suspected abuse, neglect or domestic violence
- Health Oversight Activities, such as; audits, inspections, investigation and licensure
- For Public Safety and Law Enforcement Activities, such as reporting crime in an emergency, a death that we suspect may have resulted from criminal conduct, to report a crime at one of our facilities, or to report information about a victim of a crime
- Marketing involving treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers or settings, to describe a health related product or service included in a plan or benefits. AMDx Ltd./NDL will obtain your authorization prior to using or disclosing your health information for purposes of marketing items or services to you if it is paid to make the communication. You may revoke your authorization by making a written request to [**insert contact info**]
- To assist Coroners, Medical Examiners and Funeral Directors in carrying out their job duties
- Organ and Tissue Donation
- Certain Research Projects or for reviews preparatory to research
- Disclosures necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public
- If the disclosure is required by federal or state law, such as in the case of child neglect or abuse reporting
- Military Command Authorities, if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized person who use the disclose to conduct special investigations
- Worker's Compensation Payers, as it relates to any injury and/or illness reported to or by a worker's compensation office
- For judicial or administrative proceedings if ordered by a court or in response to a subpoena
- To a correctional institution or law enforcement official if you are in inmate of a correctional facility or are under the custody of a law enforcement official to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.
- Use or disclosure necessary to initiate and complete health care treatment, payment and operations or functions by business associates, such as; installation of a new computer software system

Note: **Information with Additional Protection:** Certain types of medical information have additional protection under Arizona law. In some circumstances, we will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

.

4) **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except where otherwise described, use and/or disclose of your medical information will be not be released by AMDx, Ltd. / NDL. If you would like us to release your medical information to a party/parties not otherwise mentioned, your request must be provided in writing and will only be effective as of the date you indicate. In addition, AMDx Ltd./NDL require your written authorization to use or disclose your psychotherapy notes or to sell your health information. You may revoke any authorization to use or disclose your health information at any time by contacting [**insert contact info**], however, you understand that AMDx Ltd,/NDL may have already acted on your authorization to use or disclose your health information.

5) **WHAT ARE MY RIGHTS REGARDING MY HEALTH INFORMATION?** You have the following rights, when requested on the form(s) provided by AMDx, Ltd. / NDL:

- **The Right to Request Restrictions:** You may request certain limitations on the usage or disclosure of your health information in relation to your health care, treatment, payment or operations. However, we are not required to comply with these types of requests, unless you request that we do not share your health information with your health insurer about a service for which you (or someone other than your insurer) has paid us in full and the disclosure is for the purpose of carrying out payment or health care operations and the disclosure is not otherwise required by law.
- **The Right to Confidential Communications:** You may request that communication regarding your health information be provided in a certain way or at a location, other than the personal address you provided. When submitting such a request, you must also provide a written method of contact for yourself; i.e., alternate phone number or address.
- **The Right to Inspect and Copy:** You may review and request a copy of your medical or health record(s). For certain requests, an administrative fee to cover the cost of the request may be applied. Under limited circumstances, your request may be denied. You then have the right to request review of the denial by another licensed health care professional, as selected by AMDx, Ltd. / NDL. After the review is completed, AMDx, Ltd. / NDL will comply with the outcome.
- **The Right to Request Amendment:** You may request an amendment to your medical or health record(s), if you believe that information maintained by AMDx, Ltd. / NDL is incorrect or incomplete. However, we are not required to accept the amendment.
- **The Right to Accounting of Disclosures:** You may request a list of some of the disclosures made by AMDx Ltd./NDL of your health information. AMDx, Ltd. / NDL may apply an administrative fee for any request received after the initial request.
- **The Right to a Copy of This Notice:** You may request a paper copy of this notice at any time, even if you have been provided with an electronic copy. To obtain an electronic copy of this notice, please refer to our website, at: www.ndxlabs.com.
- **To Be Notified in the Event of a Breach**. In the event AMDx. Ltd./NDL determine that the confidentiality of your health information has been breached, you have the right to be notified.

6) **WHAT REQUIREMENTS APPLY TO THIS NOTICE?** AMDx, Ltd. / NDL is required by law to provide you with this notice and will continue to comply with the provisions outlined within, for as long as it is required by law. AMDx, Ltd. / NDL reserves the right to change the terms outlined within this notice and any such changes will be effective for all information that may be in our health records for you, as well as for all future information we receive for or by you. All revisions to this notice will be available on our website, at www.ndxlabs.com. Revised paper copies will also be available, upon request. A copy of the notice may be provided to you, each time you register to receive services by AMDx, Ltd. / NDL.

7) **WHAT IF I HAVE A COMPLAINT REGARDING PRIVACY PRACTICES?** If you believe your privacy rights have been violated, you may file a complaint with the AMDx, Ltd. / NDL Privacy Officer or with the Secretary of the United State Department of Health and Human Services. All complaints must be submitted in writing and must describe the details / situation that caused the complaint. You will not be penalized or retaliated against for filing a complaint to AMDx, Ltd. / NDL or to the Department of Health and Human Services.

AMDx, Ltd. / NDL
ATTN: Privacy Officer
2423 W. Dunlap Ave | Suite 175
Phoenix, AZ. 85021-5818
(P) 602.424.4450 | (F) 602.424.4451