BINGHAM
Nerve & Muscle
RELIEF BEGINS WITH AN ACCURATE DIAGNOSIS

800.224.1807

DATE				
LAST NAME	FIRST		MIDDLE	
PHYSICAL ADDRESS	APT. #	CITY	STATE	ZIP
MAILING ADDRESS (PO BOX) ❑ Check if same as above		CITY	STATE	ZIP
SEX ❑ M ❑ F	AGE	BIRTHDATE	MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED	
SOCIAL SECURITY NO.			HOME OR CELL PHONE	
EMPLOYED BY:	OCCUPATION:		❑ RETIRED ❑ UNEMPLOYED ❑ DISABLED	
EMPLOYER ADDRESS:		CITY/STATE	ZIP	
WHAT ARE YOUR SYMPTOMS:				
ARE YOUR SYMPTOMS RELATED TO: ❑ Work ❑ Home ❑ A motor vehicle accident ❑ Other _____				
HAVE YOU EVER HAD AN EMG/NCS BEFORE? ❑ yes ❑ no				
REFERRED BY	DATE OF RETURN VISIT			
SPOUSE (or responsible party) NAME	SPOUSE'S BIRTHDAY			
SPOUSE'S SOCIAL SECURITY NO. (TRICARE ONLY)				
IN CASE OF EMERGENCY NOTIFY & PHONE IF DIFFERENT THAN SPOUSE.				

Insurance Authorization and Assignment

I request that payment of authorized Medicare, Medigap, Commercial Carrier, or Workers Compensation benefits on my behalf, be made to Bingham Nerve & Muscle for any services provided to me by Bingham Nerve & Muscle. I authorize Bingham Nerve & Muscle to release to the Health Care Administration and its agents any information needed to determine benefits payable for related services. I understand that I am responsible for any deductible, co-pay, or services not covered by my insurance carrier. I also authorize the physician to release any information required by my insurance company and/or another physician. I give authorization and consent for treatment to Bingham Nerve & Muscle.

X_____ _____

PATIENT SIGNATURE OR LEGAL GUARDIAN (IF A MINOR) DATE

CONSENT FOR MEDICAL TREATMENT

I authorize Bingham Nerve & Muscle physicians and personnel to render medical treatment and evaluation needed. I further authorize order of other diagnostic tests and treatment that may be necessary.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I have received a copy of the Notice of Privacy Policy Practices, which contains a more complete description of the uses and disclosures of my protected health information. I am aware that the notice may be changed at any time.

I hereby authorize the release and disclosure of my protected health information for treatment, payment or health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of Bingham Nerve & Muscle.

I agree that Bingham Nerve & Muscle may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

X _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

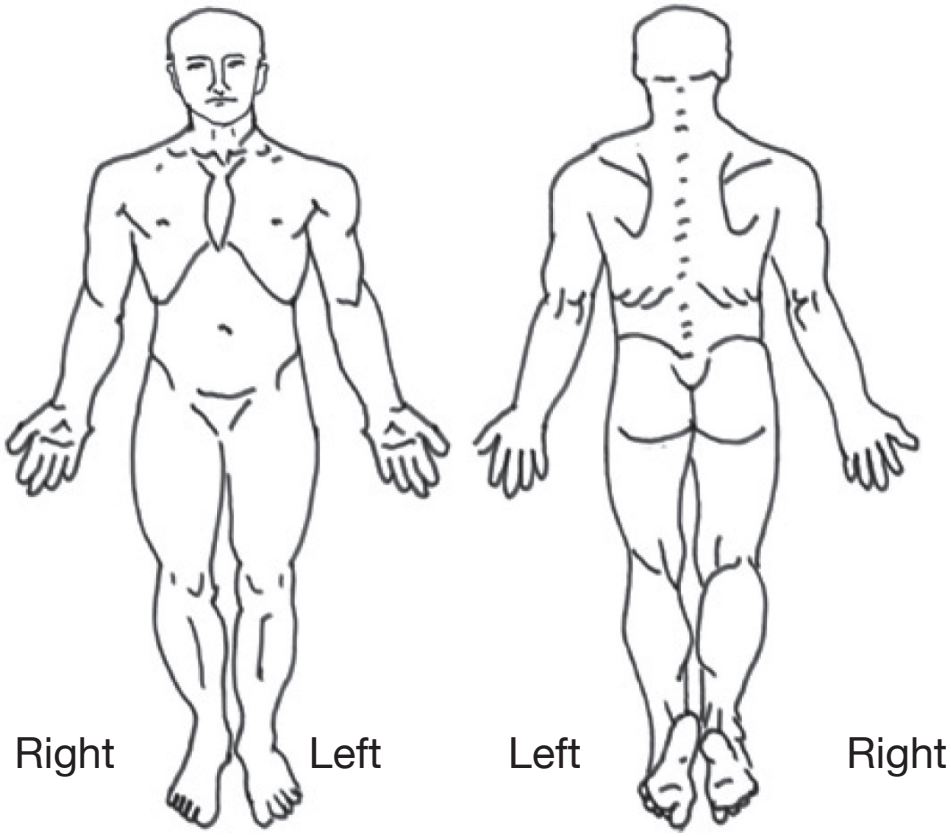
CONSENT FOR FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by Bingham Nerve & Muscle. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of my charges. I assign benefits to and authorize direct payment to Bingham Nerve & Muscle of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for all charges not paid pursuant to this agreement.

X _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

PLEASE SHADE WHERE YOU ARE HAVING SYMPTOMS



JACKSON
3035 N. Highland Ave.

CORDOVA (NEW ADDRESS)
8066 Walnut Run Rd, Suite 101

UNION CITY
1720 E. Reelfoot Ave., Suite 201

PARIS
430 S. Lake St.

DICKSON
421 Henslee Dr.

SOUTHAVEN (MISSISSIPPI)
7640 Clarington Cove, Suite B
(Across Airways Blvd from the Desoto Baptist Hospital Campus)

TUPELO (MISSISSIPPI)
634 Spicer Dr., Suite A

JONESBORO (ARKANSAS)
2241 Hill Park Cove, Suite A

NASHVILLE
28 White Bridge Pike, Suite 209

Call 800-224-1807 with questions