



Patient Account # _____

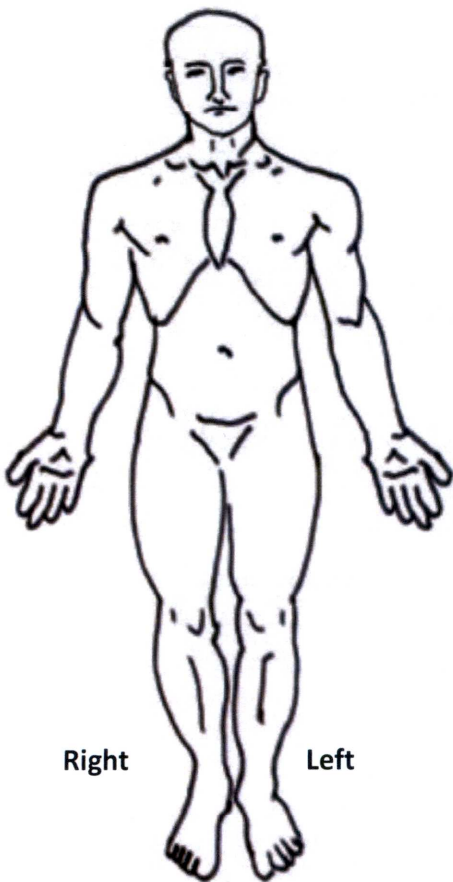
EMG/NCS _____

DATE					
LAST NAME		FIRST		MIDDLE	
MAILING ADDRESS (PO BOX)			CITY		STATE ZIP CODE
SEX:	AGE	BIRTHDATE	SOCIAL SECURITY#	HOME OR CELL PHONE	
EMPLOYED BY:		OCCUPATION:		<input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> DISABLED	
WHAT ARE YOUR SYMPTOMS:					
ARE YOUR SYMPTOMS RELATED TO: <input type="checkbox"/> WORK <input type="checkbox"/> UNKNOWN <input type="checkbox"/> MOTOR VEHICLE ACCIDENT <input type="checkbox"/> OTHER					
PRIMARY INSURANCE: (*If TriCare, Policy holder's SSN #)			SECONDARY INSURANCE: (*If TriCare, Policy holder's SSN #)		
Policy holder's Birthdate:			Policy holder's Birthdate:		
REFERRED BY:				DATE OF RETURN VISIT	
EMERGENCY CONTACT AND PHONE NUMBER:					
(FOR MINORS ONLY! PARENT OR LEGAL GUARDIAN'S INFO)					
Parent/ Legal Guardian's Name:		Birthdate:		Social Security #	
<u>Insurance Authorization and Assignment</u>					
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 (IF A MINOR) PARENT OR LEGAL GUARDIAN					
DATE					
<u>CONSENT FOR MEDICAL TREATMENT</u>					
I authorize Bingham Nerve & Muscle physicians and personnel to perform nerve and muscle testing, (EMG)/NCS).					
<u>CONSENT FOR RELEASE OF MEDICAL INFORMATION</u>					
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. Bingham Nerve & Muscle Notice of Privacy Policy Practices is available upon request, which contains a more complete description of the uses and disclosures of my protected health information. 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. 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 _____ PATIENT SIGNATURE OR (IF A MINOR) PARENT OR LEGAL GUARDIAN					
DATE					
<u>CONSENT FOR FINANCIAL RESPONSIBILITY</u>					
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 _____ PATIENT SIGNATURE OR (IF A MINOR) PARENT OR LEGAL GUARDIAN					
DATE					

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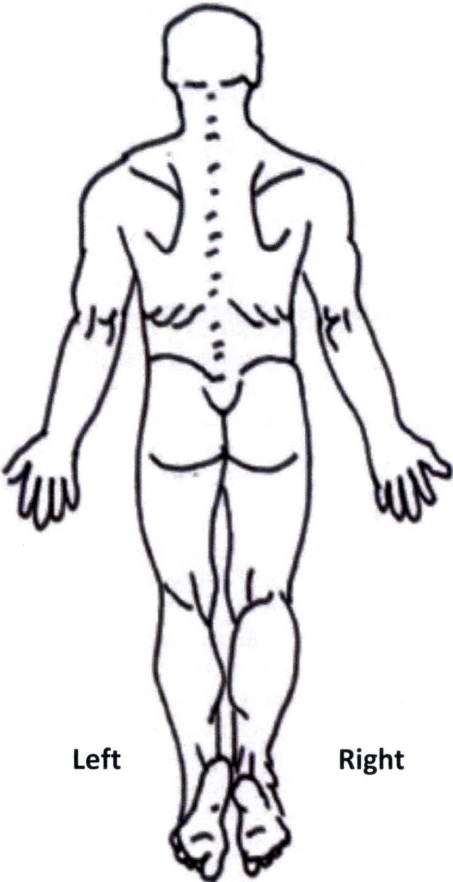
EMG/NCS _____

PLEASE SHADE WHERE YOU ARE HAVING SYMPTOMS



Right

Left



Left

Right