

NEUROLOGY ASSOCIATES OF NORWALK

637 West Avenue, Suite 200
Norwalk, CT 06850
(203) 853-5000 phone
(203) 853-5001 fax
NorwalkNeurology.com



Louis J. Cuzzone, MD
Amy M. Knorr, MD
Irina Taraban, MD
Daryl R. Story, MD
James L. Thompson, Jr., MD

Electroencephalogram (EEG) Information

An EEG, or electroencephalogram, is a test that measures the electrical activity of the brain, often referred to as brain waves. This test is performed to see how often different parts of your brain function. It records a graph of your brain waves which allows your doctor to see how your brain functions. Your doctor has asked to have this test performed because of the symptoms you are experiencing. EEGs are useful in determining the cause of episodes of loss of consciousness, dizziness, and problems with thinking and memory. EEGs are most commonly used to determine whether the event you had might have been a seizure.

A technologist will place small metal disks with wires attached to them (electrodes) on different spots on your head to record your brain waves. Each spot will be cleaned with a special substance and the electrodes will be applied with a small amount of gel to hold them in place. You will be made comfortable by lying on a bed with eyes closed. The wires are then attached to a machine which will measure and record the electrical activity of your brain. You might also be asked to breathe quickly and deeply for a few minutes or look at a flashing strobe light.

The test is painless and takes about one hour to complete. About 40 minutes of EEG recording is made and the other time is spent putting on and removing the electrodes. The areas where the electrodes have been placed will be cleaned by the technologist, however it is generally recommended that you wash your hair at home after this test is performed.

If you are having an ambulatory EEG, also called a 24 hour EEG, the electrodes are attached with a special paste designed to keep them in place for 24 hours. The head is usually wrapped in gauze to help keep the electrodes from falling off. Special instructions about what to record and how to care for the equipment will be given to you before you go home. You will return the following day to have the electrodes removed.

There are neither after effects from this test nor any special preparation. We recommend that your hair be washed and no hairspray, cream or oils applied to your hair or scalp. Any barrettes, hairpins, etc. should be removed. If you are having a 24 hour EEG we ask that you wear a shirt that buttons down the front and does not have to be pulled over your head. After the test is performed, a neurologist will read the test and send a report to your doctor. It is important that you schedule a follow-up appointment with your doctor to discuss these results.

It is our policy not to collect copays at the time of your visit for this test as many insurances do not require a copay for testing. We will submit the claim to your insurance. If a copay, deductible or co-insurance is due, you will receive a statement for this test.

It is important that you arrive on time for your appointment. Any missed appointments, or arriving more than 15 minutes late for your appointment, will result in a \$50 no show fee.

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Patient name: _____ Date of Birth: _____ Gender: Male Female

What is your marital status? Single Married Divorced Widowed Domestic Partner Preferred language: English or other: _____

Race: African American / Asian / Caucasian / Native American / Pacific Islander Ethnicity: Hispanic or Latino / not Hispanic or Latino

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Doctor: _____

Medical Insurance (primary): _____ Policy #: _____ Group #: _____

Medical Insurance (secondary): _____ Policy #: _____ Group #: _____

Emergency contact name: _____ Phone number: _____

Is the problem related to an auto accident? Yes or No If yes, date of accident: _____ Last day worked: _____

Is the problem work related? Yes or No If yes, date of injury: _____ Last day worked: _____

*If your visit is related to either a motor vehicle accident or workers compensation injury, please complete a separate motor vehicle / workers compensation form and return it to us no later than **3 business days before appointment.***

HIPAA, insurance and billing policies: I hereby acknowledge I received a copy of this medical practice's notice of privacy practices, including CT Social Security Act. I further acknowledge that I was informed that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended notice of privacy at each appointment. I authorize the viewing of external prescription history information. A prescription history contains prescription records provided by community pharmacies and pharmacy benefit managers authorize the release of information necessary to determine the liability for payment and to obtain reimbursement of any claim. The assigned will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I hereby authorize said assignee to release the benefits payable to which I am entitled, including Medicare, HMO's, private insurance and other health or insurance plans, to Neurology Associates of Norwalk, P.C. I agree the insurance information provided by me is true and correct. If this information is invalid, I agreed to be fully responsible for payment. You may use the phone numbers and addresses provided above for billing and other issues related to my care. If my insurance carrier requires a referral and I do not obtain one, I will be responsible for payment. I further agree that if my physician does not participate with my insurance, I will be responsible for payment. Neurology Associates will be happy to submit claims to your insurance company. If your insurance company requires you to obtain a referral to see a specialist, you understand it is your responsibility to obtain the referral and that if you do not do so your appointment will be rescheduled. Your co-pay or any previous balance is payable at time of service as this is a contract between your insurance company and you. You understand that you may be asked to reschedule your appointment if you're unable to make payment. Patients who are self-pay or who have insurance which we do not participate with, must pay at the time of service. We accept all major credit cards, checks and cash. It is your responsibility to make us aware of any change in your insurance coverage at least 1 week in advance of any appointment. You will be financially responsible for any claims denied due to missing or invalid insurance information at time of service. You will be responsible for any services your insurance denies as being considered experimental or not medically necessary. You must check with your insurance prior to treatment to determine what services they consider experimental or not medically necessary. If your visit is related to a **Motor Vehicle** accident, you must supply Auto Carrier claim information in addition to a letter of Med Pay benefits. In addition you must supply us with your medical insurance information to cover any claims denied or above the auto policy limits. If your visit is related to **Workers Compensation**, you must supply Workers comp insurance information in addition to a written referral from your PCP or physician who originally treated you for the injury. In addition you must supply us with your medical insurance information to cover any claims denied by Workers Comp or above the policy limits. If Neurology Associates of Norwalk does not participate with your insurance we will still be happy to submit claims on your behalf. However, you are still financially responsible to us for all services rendered. In a situation where your claim is denied or only partial payment made by a non-participating insurance you will be responsible for the balance due. This includes but is not limited to all **Motor Vehicle** and **Workers Compensation** insurances. There is a \$25 fee for any checks not honored by your bank. I understand and agree that if my account becomes delinquent and is transferred to a third-party collection agency that I will be assessed a fee of 15% of my balance being transferred to said agency. **There is a \$35 service charge for appointments cancelled or missed with less than 24 hours notice.** These policies, where applicable by law, supersede any agreements with my insurance carrier.

Patient signature: _____ Date: _____

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Motor Vehicle or Workers Compensation Claims

If your visit with us is related to either a motor vehicle accident or workers compensation injury, please complete and return this form to us no later than 3 business days before appointment. Having this information in advance of your visit is critical in assuring your claim will be processed correctly if at all. We thank you for your cooperation.

If your visit is related to a MOTOR VEHICLE accident, you must include the responsible insurance's medical payments (MED PAY) letter with this form.

Type of claim: __Motor Vehicle __Workers Compensation

Insurance Company: _____

Claims Address: _____

Insurance Adjustor's Name: _____

Adjustor's Phone Number: _____

Claim Number: _____

Date of Accident/Injury: _____

Do I really need to fill this out, I have health insurance too? Yes, unfortunately we do need your help in obtaining this information prior to your appointment. Although you have health insurance, they will not consider paying for your visit without a written determination from your motor vehicle or workers compensation insurance first. We need this information before your visit so we can submit your claim(s) to the proper insurance AND have the documentation we need if in fact motor vehicle or workers compensation denies your claim. Without this form you will be liable for the full cost of your visit(s) at the time of service even if you have active health insurance.