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

Electromyography (EMG) Information

An EMG, also known as Electromyography, is an exam preformed to evaluate the function and health of the nerves and muscles in your arms and/or legs. There are two parts to the test.

The **nerve conduction** part of the test involves stimulating a nerve with a brief small electrical impulse to the skins surface and records the response from a muscle or portion of the nerve via small metal disks places on the skin. The stimulations last for several seconds. There are no after effects from the stimulation and is safe to perform on patients with a pacemaker. The doctor should be informed if you have a pacemaker or any implanted device.

The **electromyography** part of the test usually follows the **nerve conduction** mentioned above. A sterile, disposable, Teflon coated, very thin needle electrode is placed through the skin into a muscle. The needle has a special recording device that records the natural electrical activity within the muscle. This analysis gives important information about each muscle tested as well as the controlling nerves. There may be a mild degree of discomfort with the penetration of the skin but there is no lasting discomfort. This part of the test is safe for patients who are on blood thinners.
To prepare for the test, please take a shower (or bath) before the test to remove oil from your skin. Please do not use lotion on the day of the test.

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.

NEUROLOGY ASSOCIATES OF NORWALK

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:**______________

NEUROLOGY ASSOCIATES OF NORWALK

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.