VASUDEVA G. IYER
NEURODIAGNOSTIC CENTER
Accredited with Exemplary Status by AANEM
2505 Bush Ridge Dr. Suite A, Louisville, KY 40245
Phone: (502)708-1338 Fax: (502)708-1339

Date:

Patient Name:
Referring Physician:
Appointment Date and Time:

Your Doctor/Nurse/PA has requested that you undergo EMG/NCV tests and/or a Consultation. You have an appointment to see Dr. Iyer at the above office for these tests. **Please note the following:**

1. Enclosed is a patient questionnaire, which you must fill out before your appointment and bring with you. Please DO NOT mail it back. The back page shows a map with directions and the location of the office. TARC and TARC3 no longer come to our office, so if you rely on these services you must find alternative transportation prior to your appointment.
2. You are required to bring your current insurance card (if not through Worker's Comp.) and a current photo ID. We also **require your guarantor's name** and **date of birth** be written under the insurance information section.
3. Please bring any previous EMG reports, CT scans or MRI discs/reports, as well as any blood work that you have in your possession. It is not necessary for you to acquire them yourself, as we can always request them if needed.
4. There is a page provided for you to record your current medications. You may use your own list, but please refer to the instructions on the **Medication List** page to be sure it contains all required information.
5. If you have an implanted cardiac pacemaker or defibrillator **you must inform our office** as soon as possible because it is likely we cannot perform the tests in our office.
6. If you have any specific communication or mobility needs, please be sure to **inform us in advance.**
7. If you have a recent history of fainting or frequent seizures, it is important to have someone accompany you to the appointment for safety reasons.
8. You may take of all your regular medications, including pain relievers and blood thinners, on the day of the test.
9. It is important that you read the **Test Preparation Instructions** page at the end of this packet. You will find useful information about the test and how to prepare for it.
10. Please be advised that children cannot be in the exam room during testing. **DO NOT** bring children under the age of ten with you unless you have a supervising adult to stay with them in the waiting room during the test. Doing so will likely result in your appointment being rescheduled. Not having our paperwork is not a valid reason for being unaware of our policy, it is your responsibility to ask the appropriate age to bring a child to a diagnostic test. If the patient is under the age of 18, they must have a parent or guardian with them in the exam room.
11. If you are unsure as to whether our office is aware that this visit is related to a work injury or auto accident please call us with any information **as soon as possible**, as this information must be verified before your appointment.
12. We will contact you 24-48 hours prior to your appointment time to confirm your appointment. It is important that you make an attempt to confirm the appointment with us; you may leave a message or simply reply to our confirmation text with your appointment time. Without confirmation at least 24 hours prior to your appointment time, we may have to double-book that time slot which will lead to long wait times. We consistently have many patients on our waiting list so we cannot allow potentially open slot(s) for appointments. If you are unable to keep the appointment for any reason, please inform our office as soon as possible so that another patient can be accommodated in your place. Failure to notify our office in advance may result in a $25 No Show Fee. If you think you may be late to your appointment please call our office as soon as possible. If you are more than 15 minutes late, your appointment will be rescheduled, **NO EXCEPTIONS**.

Thank you!

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Electronic Medical Records Transmission

The Neurodiagnostic Center allows **email communication with patients** for the purposes of transmission of registration papers and/or sending and receiving medical reports when the patient requests to use that option. **While we automatically send (fax or email) a copy of the report to your referring physician, you may ask that one be emailed to you as well**. This is the most efficient way to make sure that you have your own copy to give to all physicians involved in your care. The Neurodiagnostic Center uses secure and encrypted services, however, please be aware that communications via email over the internet are never 100% secure. Only indicate private, unshared email addresses in order to protect your privacy. Although unlikely, there is a possibility that information included in an email can be intercepted and read by parties other the person for whom it was intended. When sending the office an email keep personal details to a minimum, and when in doubt just call the office directly. Additionally, no one can accurately diagnose your condition from email or other written communications, and electronic communication cannot replace the relationship you have with a physician or another healthcare practitioner.

I give my consent for my medical records to be sent to the designated email address(es) below. I understand that there are risks to sending email over an encrypted transmission, but that The Neurodiagnostic Center will do everything within its power minimize that risk. Permission is granted for email communication until a written notice is provided in the office directing us to no longer use the provided email address(es).

Printed Name: _____ Date of Service: _____

Signature: _____ Date: _____

Authorized email addresses: _____ _____

_____ _____

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Patient Registration Forms

Name: Last_____First_____Middle_____

Address:_____**City**:_____**State**:____**Zip**:_____

Telephone: Home ( )_____Work ( )_____Cell ( )_____

Date of Birth:_____**Soc. Security No**:_____ **Email**:_____

Height:_____**Weight**:_____**Age**:_____**Gender**:_____**Are You Claustrophobic?**:_____

Marital Status of Patient: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent/Guardian Name: _____**Ph./Add. (if different)**:_____

Occupation:_____ **Employer**:_____

Employer's Address:_____ **City**:_____**State**:____**Zip**:_____

Emergency Contact: _____**Telephone No.**:( )_____

Family Physician (name/add./ph/fax): _____

Is this visit due to a work injury?:_____**Is there an open claim for the incident?**:_____

Date of Injury:_____**Claim No**.:_____**Contact Person**:_____

Phone/Fax:_____**Address**:_____

Is this visit due to an accident?:_____**Is there an open claim for the accident?**:_____

Date of Accident:_____**Claim No**.:_____**Contact Person**:_____

Phone/Fax:_____**Address**:_____

Is an attorney representing you in this matter?:_____

If yes, provide contact info:_____

Insurance Information:

Primary Insurance:_____Phone :( )_____

Policy ID No.: _____Group No:_____

Claims Address:_____

Subscriber Name:_____Subscriber Date of Birth:_____

Relationship to Patient:_____Subscriber SSN (if Tricare/Triwest):_____

Secondary Insurance:_____Phone :( )_____

Policy ID No.: _____Group No:_____

Claims Address:_____

Subscriber Name:_____Subscriber Date of Birth:_____

Relationship to Patient:_____Subscriber SSN (if Tricare/Triwest):_____

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NOTICE OF HEALTH INSURANCE DEDUCTIBLE AND/OR AUTO ACCIDENT POLICY

(All Patients MUST READ)

- The Neurodiagnostic Center requires a deposit -- **based upon a portion of your current remaining Health Insurance amount** -- to be made on or before the date of service for insurance plans with known deductibles.
- If your appointment is related to an auto claim, a $250 Auto Deposit is required unless you can provide documentation that your PIP has been exhausted. Once your PIP has been exhausted, your health insurance can be used. Doing so may require a deductible deposit, if you are unsure if that is the case, it is best to call the office ahead of your appointment.

Details of these policies are discussed when your appointment is scheduled. Failure to bring your deposit may result in your appointment being rescheduled. It is important to notify the office immediately if there have been any changes to your insurance plan(s) and/or claim status since the appointment was scheduled. If your insurance carrier determines that your test/visit was covered, the auto claim pays for your visit, you have no copay due or outstanding balance with our office, you will receive a full or partial refund in the mail in a timely manner. Please call our office at if you have any questions regarding your health insurance deductible or auto deposit after reading the paperwork, as waiting until right before you appointment will not be an acceptable reason to not pay your deposit and your appointment may be rescheduled.

Initial:_____

DISCLOSURE STATEMENT

The Neurodiagnostic Center is a testing facility only. A report detailing the findings and diagnostic conclusions will be sent to the referring MD within 24-48 hours. **It is your responsibility to make an appointment with your referring MD or Primary Care Physician for follow-up care. Please note that Dr. Iyer cannot provide medication or specific treatment for you.** Additionally, if you need your report sent to any doctors other than your referring physician it is important that you write the doctor's name and correct fax number on your paperwork. An attempt will be made to send your report to the additional office(s), but the in the event the office does not receive it, they may call our office to request a copy if the office/doctor's name is written on your forms. You may also request a copy be sent to you in the mail, via email, or fax provided the information is given on your paperwork or to staff **while in the office**. If you want to have the report sent to your email **you must notify us** in the office and fill out page 2.

Initial:_____

VOLUNTARY/OPTIONAL PHOTO CONSENT

I hereby give my consent to Dr. Vasudeva Iyer to take clinical photographs for future comparison, teaching, and/or scientific publication. I understand that I will **not** be identified in any way during teaching activities or in scientific publications and that participation is completely voluntary.

Initial:_____

NOTICE OF PRIVACY PRACTICES SUMMARY

Each time you go to a doctor, hospital or other healthcare facility, a record of that visit is created. Usually, this record contains your symptoms, the examination, test results, diagnosis and suggestion for further care or treatment, if applicable. This information, known as your medical record, is an important part of the care we provide for you. Although this record belongs to the facility, the information contained therein is yours, and you have a right to this information identified as "Protected Health Information." Our practice has a Notice of Privacy Practices that explains your rights and the steps we take to protect your health information that is posted in the office lobby. This policy informs in detail how we may use your information. You have a right to request this document at any time, please ask the office staff if you would like a copy.

Initial:_____

INFORMED CONSENT

Your physician has referred you for **Nerve Conduction Velocity and Needle Electromyography** (NCV/EMG) studies. An EMG and/or NCV study may help to determine the cause of muscle weakness, pain, or tingling and numbness in the arms and/or legs. It also helps to determine if the disorder or disease involves the spinal cord, nerves, muscles or nerve-muscle junctions. Some of the conditions detected by EMG include "pinched" nerves (i.e. carpal tunnel syndrome), diabetic neuropathy, nerve root compression from herniated disc, ALS, muscular dystrophy etc. Minimal bleeding may occur at the site of needle insertion and you may experience some bruising, pain, and/or tenderness in the muscle or muscles where the test was performed. Please alert our office if you bruise easily, are taking blood thinners, or are prone to excessive bleeding. If you have an implanted cardiac pacemaker or defibrillator you must inform our office as soon as possible as we may not be able to perform the test at our facility. Permission is hereby granted to Dr. Vasudeva G. Iyer to evaluate and treat me as medically necessary.

Initial:_____

RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

Release of Information: Permission is granted to disclose any or all of my medical records to any person or corporation which is or may be liable for all or portions of my medical bills, including but not limited to insurance companies, other health care service plans or worker's compensation agencies. The medical records may also be released to other physicians involved in my treatment to ensure continuity of medical care.
Financial Agreement: The undersigned agrees to accept full financial responsibility for my/patient's account in accordance with the regular rates and terms of the facility. *The undersigned is responsible for the charges if an approved referral is not obtained from my primary care physician or the medical insurance carrier.* The undersigned is providing accurate and current insurance or worker's compensation ID or claim numbers. The undersigned understands that failure to do so may result in billing the guarantor directly. Should the account be referred to a collection agency, the undersigned shall pay attorney's fees and collection charges.
Assignment of Insurance Benefits: I request my insurance carrier to pay Dr. Vasudeva G. Iyer or his designee all benefits due related to my pending claim for medical services.
Medicare B Authorization: I authorize any holder of my medical information to release to the Social Security Administration and HCFA or its intermediaries or carriers, or the billing agent of the physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I have read and approved all of the terms above except those items I personally circled and initialed.

_____ _____
Signature of Patient or Legal Guardian *Date*

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Are you giving **Photo Consent** for teaching purposes (indicated on pg 4)? ☐**Yes** ☐**No**

Do you have heart pacemaker or defibrillator? ☐**Yes** ☐**No**

Have you been told that you have a heart murmur? ☐**Yes** ☐**No**

Have you been diagnosed with hepatitis, tuberculosis or HIV/AIDS? ☐**Yes** ☐**No**

If yes, please indicate which one:_____

Are you taking anticoagulant medication (blood thinner/Aspirin)? ☐**Yes** ☐**No**

Are you allergic to latex? ☐**Yes** ☐**No**

Have you been diagnosed with diabetes? ☐**Yes** ☐**No**

Are you right or left hand dominant? ☐ **Right** ☐ **Left** ☐ **Ambidextrous**

Who is the referring physician? _____

When is your next appointment with the referring physician? _____

Who is your family physician? _____

Have you had EMG studies or an MRI in the past? _____ When/where? _____

Which side has the problem? ☐**Right** ☐**Left** ☐**Both** ☐**Other**

If your problem is related to a work injury or a motor vehicle accident, please give details.

_____

_____

_____

_____

What are your current symptoms? Give details including location and duration.

_____

_____

_____

_____

_____

What treatments you have you had?

_____

_____

_____

_____

_____

_____

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Current Medication List

All current medications must be listed below. This includes prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) medications and supplements. Additionally, please list the name, dosage, frequency, and route of administration. You may provide your own medication list, but it must contain all of this information. If you need more room feel free to write it on another page.

Medication/ Supplement Name	Dosage (ex: 250 mgs)	Frequency (Times Per Day)	Route of Administration (Ex: by mouth, Etc.)

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How to Prepare for the Tests

1. Eat normally and take your medications as usual. **If you have an implanted cardiac pacemaker or defibrillator you must inform our office as soon as possible as we may not be able to perform the test in our office.** You will not be sedated for the test and you should be able to drive afterward. We ask that if you have a history of fainting or seizures you bring someone with you in the room during the test. You are also welcome to bring someone with you if you are anxious about the test. However, please **DO NOT bring children under the age of ten** with you unless you have an accompanying adult to stay with them in the waiting room; doing so will likely result in your appointment being rescheduled. This is a small office with a relatively small waiting room, so please limit your number of guests.
2. Please make sure the area to be tested is clean. Scrub the body part to be tested to remove any body oils on the day of the test. **DO NOT USE ANY BATH OIL, LOTIONS, VASELINE, MAKEUP OR CREAMS** on the area to be tested 24 hours before your appointment time.
3. If you're being tested on the upper extremities (hands and arms), if possible, please wear a loose, short-sleeved shirt or bring one with you. If you're being tested on the lower extremities (feet and legs) we recommend wearing loose-fitting sweats or shorts. Also, please remove any jewelry or watches on your fingers, wrists, ankles, and toes prior to your appointment.

What to Expect

First, the physician will take a brief medical history. Describe your symptoms, past illnesses and medications you are currently taking. Be sure to tell the physician if you are on blood thinners (anticoagulants such as Coumadin), are highly susceptible to infections, bruise easily, have a pacemaker, defibrillator, or a heart murmur or current heart issue, have a history of hepatitis or AIDS, fainting, seizures, or a latex allergy. A brief neurological examination may follow to check muscle strength, sensations and reflexes.

Nerve Conduction Test: Recording electrodes will be taped to your skin. A stimulating electrode is held against your skin, which sends a small electrical charge along the nerve. You may feel a tingle or your muscle may twitch. The recording electrodes will detect the electrical signals as they travel along the nerve. The interval between the stimulation and the response will be recorded to determine how quickly and efficiently signals travel along the nerve. Each test will take just a few minutes, but several nerves may have to be tested depending upon the disorder.

Needle Electromyography: A thin **disposable** needle electrode is inserted into a muscle to record electrical activity, at rest and during effort. The number of muscles examined may vary depending upon your particular condition. The total testing time may be close to 30 minutes. There is a slight risk of minor localized bleeding at the site of needle insertion. Transient soreness of the tested muscles may be experienced, which responds to over-the-counter pain relievers.

Test Report

If you are seeing your referring doctor on the same day, a preliminary report will be faxed to the office no less than 2 hours after your appointment with Dr. Iyer. The final report will be sent within 24-48 hours. If the report is to be sent to other physicians, please provide the names and phone/fax numbers on your paperwork and inform the staff while you're in the office. If you have more than 2-3 doctors other than the referring physician who needs the report, it is best to just have it sent to your home or through email so you can take it wherever you may need it.

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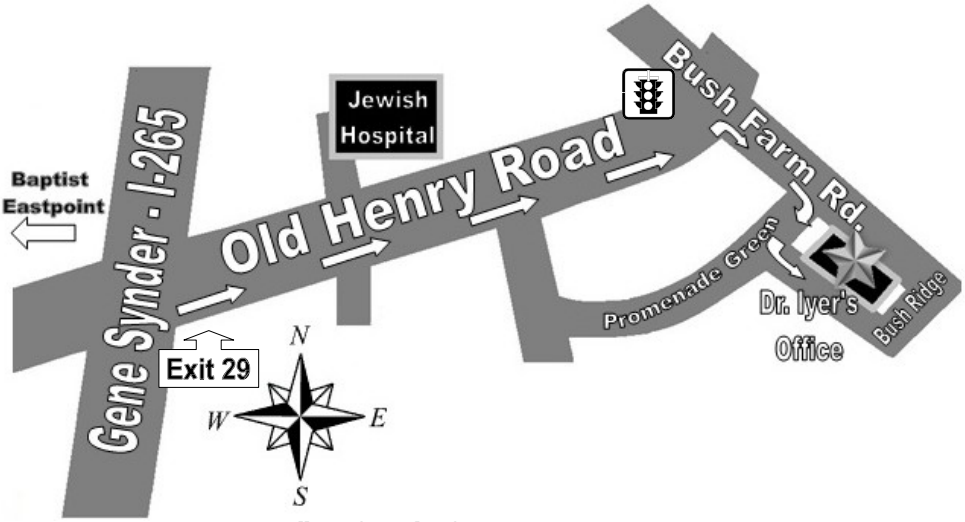
When Using GPS Enter the Intersection of Old Henry Rd. and Bush Farm Rd.



From Oldham/Henry/Carroll/Cincinnati (via I-71S):

1. Take **I-71 S**
2. Take **Exit 9A** to merge **onto I-265 S Gene Snyder Fwy**
3. Take **Exit 29** for **Old Henry Rd.**
4. Turn **Left** onto **Old Henry Rd.**

From Elizabethtown/ Central or Southern KY (via I-65N):

1. Take **I-65 N**
2. Take exit **125A** to merge onto **I-265 E/ Gene Snyder Fwy**
3. Take **Exit 29** for **Old Henry Rd.**
4. Turn **Right** onto **Old Henry Rd.**

From St. Mathews/S. Louisville/Highlands:

1. Take **I-264 E**
2. Take **Exit 19A** to merge onto **I-64 E** toward Lexington
3. Take **Exit 19B** to merge onto **I-265 N/Gene Snyder Fwy**
4. Take **Exit 29** for **Old Henry Rd.**
5. Turn **Right** onto **Old Henry Rd.**

From Jeffersonville/Sellersburg:

1. Take **I-65 S**
2. Take **exit 137** for **I-71 E** toward Cincinnati/Lexington
3. Merge onto **I-71 N**
4. Take **Exit 9A** to merge onto **I-265 S/ Gene Snyder Fwy**
5. Take **Exit 29** for **Old Henry Rd.**
6. Turn **Left** onto **Old Henry Rd.**

From the West Louisville/Portland/New Albany:

1. Take **I-264 W** . (If applicable)
2. Take **Exit 0-A** to merge onto **I-64 E (from 264)**
3. Take **Exit 6** to merge onto **I-71 N** toward Cincinnati
4. Take **Exit 9A** to merge onto **I-265 S/Gene Snyder Fwy**
5. Take **Exit 29** for **Old Henry Rd**.
6. Turn **Left** onto **Old Henry Rd**.

From New Albany/Corydon/Georgetown:

1. Take **I-64 E**
2. Take **Exit 19B** to merge onto **I-265 N/ Gene Snyder**
3. Take **Exit 29** for **Old Henry Rd**
4. Turn **Right** onto **Old Henry Rd**

From Valley Station/S. Dixie Hwy/Outer Loop/Fairdale:

1. Take **I-265 E/ Gene Snyder Fwy** (will become I-265 N)
2. Take **Exit 29** for **Old Henry Rd**
3. Turn **Right** onto **Old Henry Rd**

From Clarksville via Lewis and Clark Bridge (Bridge has Tolls)

1. Take **I-65 N** toward Indianapolis
2. Take **Exit 6A** to **265 E/IN-62 E/KY-841 S** toward Port of IN
3. Take **Exit 29** for **Old Henry Rd**
4. Turn **Left** onto **Old Henry Rd**

From Lexington

1. Take **I-64 W**
2. Take **Exit 19B** to **I-265 N**
3. Take **Exit 29** for **Old Henry Rd.**
4. Turn **Right** onto **Old Henry Rd.**

From Shelbyville Rd. (no interstate)

Turn **N** onto **N English Station Rd**
Continue onto **Old Henry Rd** (**no turns**)
Turn **Right** on to **Bush Farm Rd**.
We're the first building on the **Right**

From LaGrange Rd (no interstate)

Head **SE** on **Factory Ln**
Continue onto **Old Henry Rd** at stop sign (**Do not turn Left**)
Turn **Left** onto **Bush Farm Rd** at the Light
We're the first building on the **Right**

From Old Henry Road follow these instructions if coming from I-265: You'll pass Jewish Hospital on your left, there will be a Subway on your right. The next light is **Bush Farm Rd**. Turn **Right** onto **Bush Farm Rd.** We're the **first building on the right**. Either **Promenade Green to Kirtling Green Drive** or **Bush Ridge Drive** will take you to our parking lot. In the rear of the building look for the sign next to the door that says **Neurodiagnostic Center and 2505** above the door.