NEI OF ST LOUIS, INC.
REGISTRATION FORM

(Please Print)

Today's date:				PCP:	
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former name):	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )		Sex: ❑ M ❑ F
Street address:		Social Security no.:		Birth date: / /	Age:
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:			Employer phone no.: ( )	
Employer Address					
Referring Physician:		Primary Care Physician:			
Who should we contact in an emergency?		Phone number:			
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance					
ID Number		Group Number			
Insured's Name	Birth date: / /	Address (if different):		Home phone no.: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Secondary Insurance					
ID Number		Group Number			
Insured's Name	Birth date: / /	Address (if different):		Home phone no.: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
IF YOU HAD A WORK INJURY PLEASE COMPLETE THIS					
Date of accident:	State of Injury:	Case Manager Assigned:			
Worker's Compensation Insurance Company		Adjuster:			
Address		Phone Number:			
Claim Number		Fax Number:			
PLEASE LIST ANY PHYSICIAN WHO SHOULD RECEIVE A COURTESY COPY OF YOUR EVALUATION					
Dr:		Phone: ( )			
Address:		Fax: ( )			
Dr: Address:		Phone: ( ) Fax: ( )			

For established patients only: please review and correct any outdated information.
Reviewed by patient Date_____Initials_____

AUTHORIZATION FOR RELEASE OF INFORMATION
NEUROLOGICAL AND ELECTRODIAGNOSTIC INSTITUTE OF ST. LOUIS, INC

Patient Name: _____ Date of Birth: _____

I understand that NEUROLOGICAL AND ELECTRODIAGNOSTIC INSTITUTE OF ST. LOUIS, INC (the "Practice) has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers _____.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

_____

_____

_____

By signing below I authorize my records to be sent to me and only me at the address I provide on my registration form and/or any alternative address and/or fax number listed below. I understand at the time of request if my address or fax number is not the same as listed a new release will be required.

_____

_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Neurological and Electrodiagnostic Institute of St. Louis, Inc
Attn: Privacy Official
14825 North Outer 40
Suite 330
Chesterfield, MO 63017

_____ _____

Patient's Signature Date:

Patient Credit and Collection Policy

It is the policy of Neurological and Electrodiagnostic Institute of St. Louis, Inc. (NEI), to provide the finest quality of medical care available. In an effort to make our services available to as many patients as possible on an affordable basis, NEI employs a firm payment policy. This enables us to provide the highest level of care, and be sensitive to cost containment. In an effort to be fair to all patients, NEI has adopted the collection policy outlined below. Please read the policy to learn how the services from NEI will be provided to you in an affordable way.

NEW PATIENTS

New patients should arrive one-half hour before their scheduled appointments time to complete the patient information sheet, if you have not already done so. Please bring insurance coverage information including insurance card and type of coverage. New patients with insurance coverage are expected to pay deductibles, coinsurance or co-pay or any balance not covered by insurance at the time services is rendered. For convenience, NEI also accepts MasterCard, and Visa cards.

ESTABLISHED PATIENTS

Please bring insurance coverage information with you each visit. New and established patients are always welcome to pay for services performed or to charge services to their credit card.

Patients who have large bills from NEI as a result of extended care and who are unable to make full payment as a result of financial difficulties should contact our claims analyst. It is the policy of this office to help work out payment terms to patients in financial need, but we can only do so if the claims analyst is contacted to make payment arrangements, and financial need is proven.

INSURANCE

NEI physicians participate in a variety of insurance plans. It is the patient's responsibility to know the terms of their own plans. NEI will abide by signed insurance contracts as a participating provider. Patients covered under participating plans will be responsible for deductible and co-payments in accordance with their specific plans. Please call your insurance company if you have questions about your policy.

It is also very important to advise us of your insurance carrier's pre-authorization requirements regarding the following: diagnostic, laboratory or other outpatient testing. We need to be aware of any specific requirements regarding where procedures can be performed according to your insurance carrier's plan. You are responsible for ensuring that proper authorization is obtained prior to services being rendered on either an inpatient or outpatient basis.

We understand questions may arise regarding your account and these should be discussed with our claims analyst. We will be happy to help you receive maximum benefits; however the arrangement of the insurance companies to pay for medical care is between you and your insurance company.

COLLECTIONS

Should it be necessary to turn your account over for collections you will be held responsible for any additional collection, court costs, and/or attorney fees.

LITIGATION

Our services are provided in good faith. Our bill is between you and your doctor. For circumstances where you are required to hire an attorney for compensation, we do not accept "letters of protection" from your attorney. We would expect payment in full for services or you would need to contact our claims analyst to work out payment terms. WE WILL FILE YOUR HEALTH INSURANCE FORMS AS A COURTESY. WE IN NO WAY BECOME INVOLVED IN THIRD PARTY LIABILITY.

WORKER'S COMPENSATION

NEI accepts worker's compensation benefits payable directly to NEI. In the event that you fail to file a claim for worker's compensation benefits for this illness or condition, or it is determined by the worker's compensation carrier that the illness or condition is not a result of a compensable worker's compensation case you are responsible for the full billed amount for services rendered.

You authorize NEI to release information acquired in the course of your examination or treatment to your worker's compensation carrier.

SUMMARY

If you have any questions regarding our collection policies, please contact our claims analyst to discuss them. Our analyst is familiar with most of the major insurance carriers and may be able to answer questions regarding your coverage or direct you to people who can do so. If a problem comes up that you don't anticipate and you are unable to pay your bill, please contact our office. This will let us know that you are receiving your bill and are not making efforts to avoid payment. Thank you for being cooperative in our collection policy and thank you for selecting NEI as your provider of health services.

By signing below you acknowledge that you understand and agree with the above policies, you also acknowledge that if you fail to make any payments for which you are responsible in a timely manner, you will be responsible for all costs of collecting funds owed, including court cost, attorney fees, and collection agency fees if applicable.

I fully understand the above information and I understand my responsibility to pay for the services provided and billed.

Signature: Patient/Guardian/Responsible Party Date

NEI Representative Date

PATIENT QUESTIONNAIRE/HEALTH HISTORY

Name: _____ Date: _____

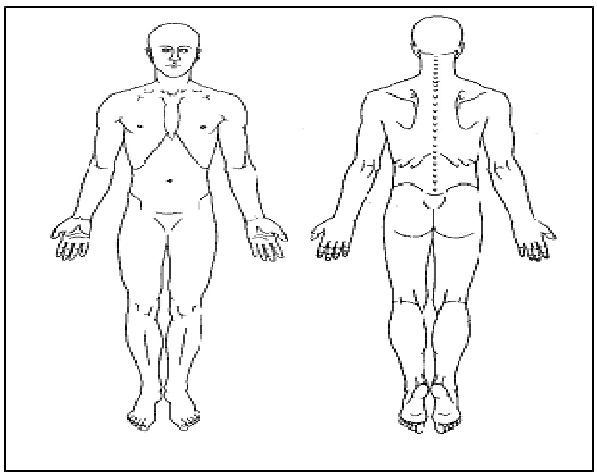
To insure you receive a complete and thorough consultation, please provide us with important background information on the following form. If you do not understand the question, our receptionist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Please note areas of pain on drawing, using the following symbols to indicate type of pain:

XXXX - Stabbing ///// - Burning +++++ - Numbness
0000 - Ache ZZZZ - Shooting >>>>> - Electric



2. When did your symptoms begin? _____
(Please indicate a specific date if possible)

3. Was the **onset** of this episode gradual or sudden?
(1) Gradual (2) Sudden

4. Which of the following **best describes** how your symptoms occurred? (if your condition is post-surgical please indicate as per original injury)

(1) lifting
(2) a MVA (car accident)
(3) a fall
(4) overuse
(5) trauma
(6) degenerative process
(7) during recreation/sports
(11) throwing
(12) incident at work
(13) unknown
(14) other _____

5. Since onset, are your symptoms getting: (check one)
(1) better (2) worse (3) not changing

6. Have you had similar symptoms in the past?
(1) yes (2) no

More than one episode? Yes No

7. Nature of pain/symptoms (check all that apply)
(1) sharp (3) aching (7) constant
(2) dull (5) periodic (8) other
(3) throbbing (6) occasional _____

8. As the day progresses, do your symptoms: (Check one)
(1) increase (2)decrease (3) stay the same

9. Does the pain wake you at night? (1) No (2) Yes

10. Do you have pain/stiffness/numbness/tingling upon getting out of bed in the morning? (1) Yes (2) No

11. Since the onset of your current symptoms have you had:
(1) any difficulty with control of bowel or bladder function
(3) numbness
(4) any dizziness or fainting attacks
(5) weakness
(6) unexplained weight change
(7) night pain/sweats
(8) malaise (vague feeling of bodily discomfort)

12. What aggravates your symptoms?

_____

_____

13. What relieves your symptoms?

_____

_____

14. Have you had any of the following tests?
Indicate when and where:
(1) None
(2) NCS
(3) x-rays
(4) CT Scan
(5) MRI Scan
(6) Arthrogram
(7) Myelogram
(8) Bone Scan
(9) Epidural Steroids
(10) Selective Nerve Block
(11) Trigger point injections
(12) Manipulations
(13) Sympethectomy
(14) Rhizotomy
(15) other

Where was the test performed and when:

_____

_____

_____

For established patients only:
Please review the form, make any changes to your symptoms and initial and date next to each change.
Initial and date the bottom of each page to document you have reviewed the information. Please ask any staff member if you have any questions or concerns.

Reviewed by patient on Date Initial	Reviewed by patient on Date Initial	Reviewed by patient on Date Initial	Reviewed by patient on Date Initial

PATIENT QUESTIONNAIRE/HEALTH HISTORY

PAST MEDICAL HISTORY

Please list all other current medical problems as well as major illnesses you have had in the past with approximate dates.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Please list **ALL OPERATIONS** you have had in the past with approximate dates.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

Please list **ALL CURRENT MEDICATIONS** (If needed please ask for an additional list)

Medications	Dosage	Frequency	Route of Administration
1			
2			
3			
4			
5			

Medications	Dosage	Frequency	Route of Administration
6			
7			
8			
9			
10			

Prescribing MD: _____

Phone : _____

Allergies: _____

Drug Allergies: _____

Are you currently taking any of the following over the counter medications?

(1) Aspirin
(2) Tylenol
(3) Steroids
(4) Antihistamines
(5) Vitamins/mineral supplements
(6) Advil/Motrin/Aleve
(7) **COUMADIN**

Current weight: _____ Current height: _____

(Circle one) Are you **Left handed** or **Right handed**?

FAMILY HISTORY

Are there any medical diseases conditions or problems that run in the family? Yes or No

If yes, please tell us what they are and the relationship of that person to you.

Please DO NOT write names of your family members.

_____

SOCIAL AND PERSONAL HISTORY:

Do you smoke? Yes _____ No _____

If you smoked and quit, date you quit? _____

If you smoke, how many packs per day? _____

How long have you been smoking? _____

Do you drink? Yes _____ No _____

If you drank and quit, when did you quit? _____

If you drink, how many drinks per week (approximately)? _____

Have you ever had a problem with alcohol or drugs? _____

Are you (Circle one)

Single Married Divorced Separated Widowed

Spouse's occupation (If applicable): _____

Current living arrangement (Circle one):

Live alone with spouse with roommate with parents/siblings Significant other

Please circle your highest level of education:

(1) Grade school (2) High School (3) College (4) Vocational (5) Graduate Level (ie after college degree)

Where do you work and in what status?

(If retired, list most recent place of employment and date of retirement)

_____

Hobbies: _____

For established patients only:

Reviewed by patient on Date	Initial	Reviewed by patient on Date	Initial	Reviewed by patient on Date	Initial	Reviewed by patient on Date	Initial

PATIENT QUESTIONNAIRE/HEALTH HISTORY

Review of Systems: Please review the following symptoms and check "Yes" or "No" based on your current or recent symptoms.
Please list any other conditions that have not been included. Please follow up with your referring physican regarding any positives from the list below.

Constitutional	Yes	No
Fever	☐	☐
Chills	☐	☐
Loss of appetite	☐	☐
Night Sweats	☐	☐
Excessive weight gain	☐	☐
Excessive weight loss	☐	☐
Malaise	☐	☐
Excessive sleepiness	☐	☐
Unable to sleep	☐	☐

Other condition list _____

Neurological	Yes	No
Headache	☐	☐
Tremors	☐	☐
Numbness in the feet/legs	☐	☐
Numbness in the arms/hands	☐	☐
Weakness in the legs	☐	☐
Weakness in the arms	☐	☐
Trouble walking	☐	☐
Poor balance	☐	☐
Falls	☐	☐
Loss of consciousness	☐	☐
Seizures	☐	☐
Loss of memory	☐	☐
Confusion	☐	☐
Difficulty in speech	☐	☐
Trouble chewing	☐	☐
Trouble swallowing	☐	☐
Vertigo	☐	☐
Concussion	☐	☐

Other condition list _____

Cardiovascular	Yes	No
Chest pain	☐	☐
Palpitations	☐	☐
Shortness of breath at rest	☐	☐
Shortness of breath on lying flat	☐	☐
Leg swelling	☐	☐
Syncope/fainting spells	☐	☐
Heart murmurs	☐	☐
Heart failure	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐

Other condition list _____

Eyes	Yes	No
Double vision	☐	☐
Loss of vision	☐	☐
Decreased vision in the eyes	☐	☐
Glaucoma	☐	☐

Other condition list _____

Respiratory	Yes	No
Cough	☐	☐
Wheezing	☐	☐
Blood in sputum	☐	☐
Shortness of breath	☐	☐

Other condition list _____

Musculoskeletal	Yes	No
Back pain	☐	☐
Neck pain	☐	☐
Muscle weakness	☐	☐
Muscle pain (myalgia)	☐	☐
Fatigue	☐	☐
Muscle wasting	☐	☐
Muscular cramps	☐	☐
Joint pains	☐	☐
Joint swelling	☐	☐
Joint stiffness	☐	☐

Other condition list _____

Endocrine	Yes	No
Diabetes	☐	☐
Thyroid disease	☐	☐
Excessive thirst (polydipsia)	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Sexual dysfunction	☐	☐

Other condition list _____

Ear/Nose/Throat	Yes	No
Ringing in the ears (tinnitus)	☐	☐
Dizziness	☐	☐
Vertigo	☐	☐
Loss of smell (anosmia)	☐	☐
Loss of taste (aguesia)	☐	☐
Hoarseness of voice	☐	☐
Decreased hearing/deafness	☐	☐
Sores in mouth	☐	☐

Other condition list _____

Hematological	Yes	No
Unusual bleeding	☐	☐
Sickle cell disease	☐	☐

Other condition list _____

Gastrointestinal	Yes	No
Loss of bowel control	☐	☐
Rectal bleeding	☐	☐
Jaundice	☐	☐
Gastric ulcer	☐	☐
Gastric bleeding	☐	☐
Hepatitis	☐	☐
Pancreatitis	☐	☐

Other condition list _____

Genitourinary	Yes	No
Loss of urine control	☐	☐
Urinary urgency	☐	☐
Blood in urine	☐	☐
Dark-colored urine	☐	☐
Kidney stones	☐	☐
Impotence	☐	☐
Sexually-transmitted disease	☐	☐

Other condition list _____

Skin	Yes	No
Rash	☐	☐
Itching (pruritus)	☐	☐
Photosensitivity	☐	☐
Tumors	☐	☐
Abnormal loss of hair	☐	☐
Pitting on the nails	☐	☐

Other condition list _____

Allergy	Yes	No
Frequent infections	☐	☐

Other condition list _____

Others _____

_____

_____

For established patients only:

Please review the form, make any changes to your symptoms and initial and date next to each change.
Initial and date the bottom of each page to document you have reviewed the information. Please ask any staff member if you have any questions or concerns.

Reviewed by patient on Date Initial	Reviewed by patient on Date Initial	Reviewed by patient on Date Initial	Reviewed by patient on Date Initial

About Your Electrodiagnostic Test

There are two different types of electrical tests of nerves and muscles: a nerve conduction velocity test (NCV) and a needle electromyogram (EMG). NCVs test how well a nerve sends electrical signals, and EMGs test the electrical activity of muscles. These tests help evaluate symptoms such as numbness, tingling, pain, weakness, fatigue and cramping, and may help your referring doctor diagnose your condition and determine your appropriate treatment.

On the day of your test

Before your test, Dr. Phillips will enter general information about you into the computer and tell you about the test. He will also tell you approximately how long the test may take, but this is only an educated estimate; the test may change as he works through the process. You may require a more detailed study to accurately diagnose your problem, and Dr. Phillips always says, "I'm done when I'm finished." What you feel or hear during your test does not indicate the severity of your condition, so you do not need to worry about comparing things or describing what you are feeling during the test.

This is a technical study and involves many measurements and calculations. Dr. Phillips will be paying careful attention to the testing process and will be intently focused on the NCV/ EMG machine. So do not worry if he is not very talkative.

Nerve conduction velocity (NCV) tests

A nerve conduction velocity test is a study of your nerves. Nerves are small cables that connect the brain and spinal cord with the rest of the body. Nerve damage can cause tingling, pain, loss of sensation and weakness. Nerve tests allow the doctor to study the electrical signals along the nerves to help determine where the problem may be located.

In preparation for the test, Dr. Phillips will place small painless metal discs (electrodes) on your skin and hold them in place with medical tape. Dr. Phillips uses hypoallergenic tape, but it's still a good idea to wash up after the test. He will mark the points where the nerves will be stimulated and will ask you to hold the extremity being studied in certain positions (for example, your palm up or your elbow flexed). The nerve is then stimulated with small electrical shocks delivered to the surface of the skin. These shocks are very brief (a tiny fraction of a second), and feel something like the electric shock from touching a metal door knob after walking on carpeting. After stimulation, the nerve responds by sending its own signal. This signal is recorded and analyzed by the computer. These small shocks have no lasting effects and cannot cause any harm. There are no side effects from nerve conduction studies.

Usually several nerves are studied depending upon the location and type of symptoms you are experiencing.

Dr. Phillips has had the test many times and knows that it can be uncomfortable, so he tries to do it as quickly but carefully as possible. Dr. Phillips has performed tens of thousands of nerve tests throughout the course of over 25 years.

Electromyography (EMG) tests

An EMG is a test of the function of muscles. A very small, thin needle is inserted through the skin into the muscle. It is the same size needle used by diabetics to give themselves insulin shots. A new sterilized needle is used on each patient and is thrown away after the test. The needle records the electrical signals inside the muscle and sends these to the computer. The doctor can see and hear how your muscles and nerves are working by the electrical signals made by your muscles. Again, don't be concerned about comparing the sounds, or alarmed by any differences that you hear. Being stuck by a needle, even a tiny one, is not very comfortable, but Dr. Phillips will do it as quickly and easily as possible.

Preparing for your test

Please tell the doctor if you are on any blood thinners such as Coumadin (Warfarin), or have a blood clotting or bleeding disorder, or have a pacemaker or any implantable device in place. These conditions generally do not preclude performing the test.

Let the doctor know if you have a latex allergy and he will use latex-free gloves.
In the past, people who had to take antibiotics prior to dental procedures (usually for heart valve conditions) also took antibiotics for EMG tests. However, current standards do not require prophylactic antibiotics. You might think of it this way: if you would take an antibiotic if you stuck yourself with a small sewing needle, then you should take an antibiotic if you have an EMG test; otherwise, antibiotics are not necessary.

You may eat, drink and take your medications, including pain medications, before and after the test. Please don't put any creams or lotions on parts of your body to be examined, or wash them off prior to the test.

After your test

You may drive and return to work and any normal activities after your test. Dr. Phillips will analyze your test results and fax a report to your doctor on either on the same day or within 24 hours. You should follow up with your referring doctor for your test results.

Please sign below that you have read the above information.

_____

Patient Signature Date