RISE DIAGNOSTICS
LOCAL.ACCESSIBLE.DIFFERENT

Anchorage / Wasilla / Palmer
Phone 907-205-5945
Fax 907-205-5948
www.RiseEMG.com

Patient Information

Patient Name (***First / MI / Last***): _____ DOB: _____

SSN: _____ Sex: ***Male / Female*** Relationship Status: ***Single / Married / Separated / Divorced / Widowed***

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

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

Cell #: _____ Home #: _____ Work #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Insurance Information

[ ] See Copy of Card(s)

Primary Insurance Company: _____

Policy ID: _____ Group #: _____

Insured: _____ DOB: _____ SSN: _____

Secondary Insurance Company: _____

Policy ID: _____ Group #: _____

Insured: _____ DOB: _____ SSN: _____

[ ] Workers Comp: Case #_____ Date of Injury_____

_____ _____

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

_____ _____

Witness Signature Date

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HIPAA Acknowledgement and Consent / Privacy Practices

I, _____ acknowledge that I have been provided the HIPAA Notice of Privacy Practices by ***Rise Diagnostics***. I acknowledge that the HIPAA Notice of Privacy Practices describes the use and disclosure of my protected health information (PHI), and identifies my rights and the duties of which ***Rise Diagnostics*** must uphold.

1. Use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPHO).
2. Call my home or other designated locations to speak in person or leave a voice message about any items that assist the practice in carrying out TPHO. Including, but not limited to: appointment reminders, insurance items, my clinical care, and diagnostic results.
3. Send mail to my home or other designated location any items that assist the practice in carrying out TPHO. Including, but not limited to: appointment reminders, patient statements, and insurance items.
4. I have the right to request that ***Rise Diagnostics*** restrict how my PHI is used and/or disclosed to carry out TPHO. However, the practice is not required to agree with my requested restriction, but if they do, they are bound to this agreement.
5. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ***Rise Diagnostics*** may decline to provide treatment to me.

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to be released to the following:

Other: _____

[ ] *Information is not to be released to anyone*

_____ _____

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

_____ _____

Witness Signature Date

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Financial Policies

I, _____ am responsible for the payment of all charges associated with my visit. As a courtesy, and for my convenience, ***Rise Diagnostics*** will bill my insurance company when I have provided my insurance information. I am responsible for deductibles, co-payments, co-insurances, and uncovered services at the time services are rendered. I am responsible for contacting my insurance carrier if I am unsure of my coverage. If the insurance payment is not received within 60 days of billed charges, I am immediately responsible for the full account balance.

- All co-payments, deductibles, and/or co-insurance are due at the time of service.
- If proof of insurance cannot be provided, patient will be deemed "self-pay", and payment will be due in full at the time of service.
- Private insurance is a contract between you and your insurance company. ***Rise Diagnostics*** will not be involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. ***Rise Diagnostics*** will supply information as necessary.
- If the patient is a minor, in the case of separation or divorce, the parent bringing the minor in for their appointment is responsible to pay for services.
- Any balances on your account must be paid in full before you will be seen again, unless payment arrangements have been made with the billing department.
- Accounts with a balance of $10 or less will not generate a statement. Please refer to your insurance explanation of benefits (EOB) to see if you owe a balance.
- A fee of $35 will be charged to the patient for any returned checks marked for NSF. The patients account will be flagged until the debt has been paid. Payment must be made by cash, credit card, or money order.
- Methods of payment accepted: cash, personal checks, Visa, and MasterCard.

_____ _____

Patient Signature (Parent/Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date

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Medical History Questionnaire

Patient Name: _____ DOB: _____

MEDICATIONS: If you are you currently taking any prescription and/or non-prescription medications please list below.

Medication	Condition

SURGERIES & PROCEDURES: Please list any surgeries and/or procedures you've had in the past.

Surgeries & Procedures	Date and/or Year

_____ _____
Patient Signature (Parent/Legal Guardian if patient is a minor) Date

_____ _____
Witness Signature Date

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PERSONAL MEDICAL HISTORY: If you have had any of the following conditions, please indicate.

Condition	Yes	No	Comments
Low Back Pain	☐	☐	
Numbness in the Legs	☐	☐	
Neck Pain	☐	☐	
Numbness in the arms	☐	☐	
Numbness / Tingling in the hands	☐	☐	
Numbness / Tingling in the feet	☐	☐	
Burning Sensation	☐	☐	
Sensation of pins and needles	☐	☐	
Weakness in the arms	☐	☐	
Weakness in the hands	☐	☐	
Weakness in the legs	☐	☐	
Overall Muscle Weakness	☐	☐	
Loss of sensation or decreased sensation in hands	☐	☐	
Loss of sensation or decreased sensation in feet	☐	☐	
Radiating pain in the arms	☐	☐	
Radiating pain in the legs	☐	☐	
Diagnosed with diabetes	☐	☐	
Diagnosed with neuropathy	☐	☐	
Dizziness / Vertigo	☐	☐	
Headaches	☐	☐	
History of falls due to dizziness or unsteady gait	☐	☐	
Hypertension or Hypotension	☐	☐	
Blurred vision	☐	☐	
Hearing problems	☐	☐	
Fevers or chills	☐	☐	
Easily fatigued	☐	☐	
Dramatic weight gain, or weight loss	☐	☐	
Lack of appetite	☐	☐	
Shortness of breath or coughing	☐	☐	
Heart palpitations	☐	☐	
Balance or coordination problems	☐	☐	
Bowel or Bladder Incontinence	☐	☐	
Depression or Anxiety	☐	☐	
Do you have an implanted Cardiac Pacemaker or Defibrillator?	☐	☐	

_____ _____

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Electromyography Laboratory Authorization & Consent for Testing

Electromyography (EMG) and Nerve Conduction Study (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscle or the junction between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of the body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscle and it may be repeated on several muscles. You will also be asked to contract your muscles during the EMG.

There are certain inherent risks with EMG/NCS. During EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory tests and muscle biopsies. There may also be other risks depending on your medical condition; please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock-like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risks depending on your medical condition; please discuss this with your referring physician or with you electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedure explained to me.

_____ _____

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

_____ _____

Witness Signature Date