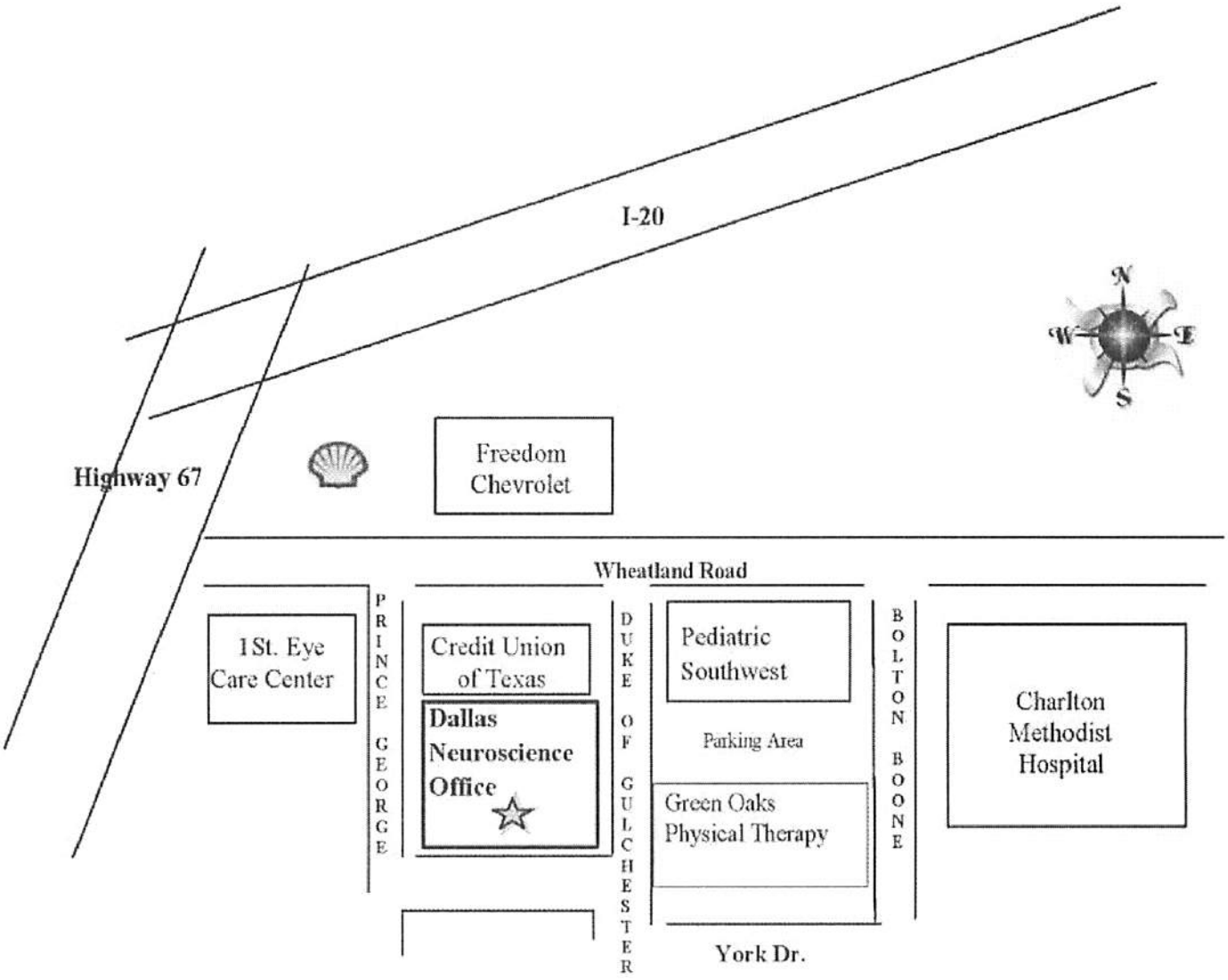
DNS

OFFICE LOCATION MAPS: 1001 ROBBIE MINCE WAY, DESOTO, TX 75115

OUR BUILDING HAS A DARK GREEN SHINGLE ROOF, AND WILL SAY "DNS NEUROLOGY" WE ARE DIRECTLY BEHIND THE CREDIT UNION OF TEXAS BANK.



Richard Ahn, M.D.
Dallas Neuroscience, PA
1001 Robbie Mince Way, DeSoto, TX 75115
Phone: (214) 622-6300, Fax: (214) 622-6310

What is an EMG /NCS Test?

Electromyography (EMG) is a diagnostic procedure to assess the health of muscles and nerves. Neurons transmit electrical signals that cause muscles to contract. An EMG translates these signals into graphs, sounds or numerical values that a specialist interprets. An EMG uses tiny devices called electrodes to transmit or detect electrical signals.

During a needle EMG, a needle electrode is inserted directly into a muscle which records the electrical activity in that muscle.

A nerve conduction study (NCS), another part of an EMG, uses electrodes taped to the skin to measure the speed and strength of signals traveling between two or more points.

Both tests may result in some discomfort, but are usually well tolerated.

EMG testing can provide your doctor with specific information about the extent of nerve and /or muscle injury and may also determine the location of nerve injury and problems with nerve to muscle signal transmission.

How to prepare for your EMG /NCS test

Eat your normal meal on the day of the test and continue any medication you are taking unless otherwise instructed. Take a shower or bath before your exam in order to remove oils from your skin. Do not apply creams/ lotions/ oils on hands, arms, legs and feet.

The doctor conducting the EMG NCS test will need to know if you have certain medical conditions.

Please inform us if you:

•Have a heart pacemaker/ implanted defibrillator or any other electrical medical device
•Take blood thinning medications
•Have a blood clotting disorder that causes prolonged bleeding

What are the risks of EMG /NCS testing?

EMG is a low risk procedure, and complications are rare. There is a small risk of bleeding and infection where the needle electrode is inserted.

What do I expect after an EMG/NCS test?
You may experience some muscle soreness and temporary minor bruising where the needle electrode is inserted into your muscle. This bruising should fade in several days. If it persists, contact your primary care doctor.
A report that includes the results and an interpretation will be sent to your doctor who will discuss the results with you.

DALLAS NEUROSCIENCE, P.A.

PATIENT INFORMATION FORM

Name (First) _____ (MI)_____ (Last)_____ Date of Birth_____

Street Address_____ Apt #_____ Sex M / F

City_____ State_____ Zip Code_____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

(Please only list phone numbers where you can be reached)

Contact Preference (circle): Home / Cell For Cell Phones: Consent to TEXT Reminders: Y / N

Social Security #_____ Marital Status S M D W

E-mail _____ Race _____

Are you under the care of a nursing home or inpatient rehab facility? Y/ N ***Preferred Lab Facility** _____
If **YES**, STOP HERE and inform the front desk immediately.

Employer_____ Occupation _____

Referring Physician_____ Phone (_____) _____

Referring Physician Address_____ Fax (_____) _____

Spouse's Name_____ Spouse's Date of Birth_____

Emergency Contact Name _____ Phone (_____) _____

Relationship to Patient _____

Pharmacy _____ Phone (_____) _____

Pharmacy Address / Location_____

PATIENT INSURANCE INFORMATION

Primary Insurance Company_____ Ins. ID # _____

Group #_____ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name_____ Date of Birth _____ SSN_____

Secondary Insurance Company_____ Ins. ID # _____

Group #_____ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name_____ Date of Birth _____ SSN_____

I hereby assign all medical and/or surgical benefits to DNS, P.A. I understand that I am financially responsible for all charges, whether paid or not paid by my insurance company. I also authorize the physician to release any medical information and records, if needed, to assist reimbursement from the insurance company. I authorize DNS, P.A. to provide medical treatment. **We require a 24-hour cancellation/reschedule notice. Not showing up for an appointment without proper notice will result in a $25 fee due to the office before rescheduling. Multiple or consecutive no-shows/same-day cancellations will result in dismissal from the practice. To avoid penalty, please contact the office 24 hours before your scheduled appointment.**

Patient Signature_____ **Date**_____

Responsible Party Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

This notification does not have an expiration date and will remain in force unless I decide to update or change it.

PATIENT NAME (Please print): _____

DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT (if other than patient): _____

SIGNATURE: _____

DATE: _____

I hereby authorize Dallas NeuroScience, P.A. to release my personal medical information to the persons listed below. **Please write in "None" if you do not authorize any other persons to have access to your information.** You may continue on the back if more space is needed.

FULL NAME	**RELATIONSHIP TO PATIENT**	**PHONE NUMBER**

Richard Ahn, M.D.
Dallas NeuroScience, PA
1001 Robbie Mince Way, DeSoto, TX 75115
Phone: (214) 622-6300, Fax: (214) 622-6310

I, the undersigned patient, hereby affirm that the services received from Dr. Richard Ahn will be filed on my medical insurance policy and I will not now, nor in the future, file worker's compensation, an automobile accident claim, or any other accident/injury insurance for **this** service.

If any medical equipment is loaned to me, the undersigned patient or guardian, by Dallas NeuroScience, PA, I agree to return it in the condition it was loaned to me in. Any damage or abuse to the equipment will result in me being held financially responsible for the full cost of the equipment. Additionally, I agree to return any and all equipment loaned to me at the time/date specified by the technician at the time of service. **A $25 per day late fee will be assessed for every day after the agreed-upon date to return the equipment, up to 10 business days (up to $250). After the tenth business day, I understand I will be held responsible for the full cost of the equipment. I understand and agree that any charges due to damage/abuse OR failure to return equipment will be billed directly to me, and that my insurance will not be billed.**

I, the undersigned patient or guardian, hereby affirm that the patient listed below is not under the care of any nursing home facility or inpatient rehab facility at the date of service. If the patient is under the care of a skilled nursing facility, I have informed the office staff of this information.

All patients must read and sign this form before receiving services.

_____ _____
Patient's Name (Please Print) **Patient's Date of Birth**

_____ _____
Relationship to Patient (If other than patient) **Date**

_____
Signature

Richard Ahn, M.D.
Dallas NeuroScience, PA
FINANCIAL POLICY

Thank you for choosing the offices of Dr. Richard Ahn as your health care provider for neurological services. As part of our professional relationship, it is important you have an understanding of our financial policy.
All patients must read and sign this form before receiving services.

As medical providers, our relationship is with you, the patient, and NOT your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is your responsibility to know and understand the level of services covered by your insurance company.**

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information, your insurance company may deny the claim. **If the claim is denied, you will be financially responsible for the services rendered. That includes office visits, procedures, telemedicine visits and phone calls that are personally returned by the physicians, Dr. Richard Ahn and Rosa Luna, NP.**

Your co-payment, co-insurance, and/or deductible are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, these estimates we receive from your insurance company are estimates alone. You are responsible for paying the full amount determined by your insurance company once they have filed the claim – regardless of the estimation we are given. Please be aware that some or all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

You must provide us with your most current billing information, including address and telephone numbers. If your information changes, it is your responsibility to provide us with the updated information.

If you have a balance on your account, we will send a statement to you as notification of this balance.
Payment is due in full upon receipt of this statement. If you are not able to pay the balance in full, you must contact our office to discuss a payment schedule. **If you fail to contact our billing office to arrange payment, or do not make payments as agreed upon in your payment schedule, your account may be referred to a professional collection agency. If this occurs, you will no longer be able to receive services from any of the physicians encompassing Dallas NeuroScience, PA until your account is paid in full.**

If you submit payment by check and the bank returns the check unpaid for any reason (e.g. insufficient funds), you will be responsible for a $35.00 returned check charge. This charge must be paid in full plus the amount of the returned check, before any further services will be provided to you. You understand that we will not accept any checks in the future from you; any future payments must be made by cash or credit/debit card.

It is your responsibility to keep your account up to date and not carry a balance. You understand and accept that balances left on your account may affect your ability to see our providers. Failure to keep your account balance current may require us to cancel or reschedule your appointment.

I have read and understand this financial policy. This record of agreement is in effect for the duration of my treatment by these providers.

_____ _____
Patient's Name (Please Print) **Patient's Date of Birth**

_____ _____
Relationship to Patient (if other than patient) **Date**

_____
Signature of Patient or Responsible Party

Dallas NeuroScience, PA

Payment Policy:

I understand that I am required to pay *any* amount my insurance deems my responsibility, including coinsurance, and deductible, at the time services are rendered. If unable to pay at time of service, my appointment may be rescheduled. I am ultimately responsible for my account regardless of insurance.

Charges for Non-Medical Services:

Only **Cash** for these services.

- Medical Records $25
- Billing Records $25
- FMLA Paperwork $40
- Ins Disability Forms(multiple pages) $70
- 1 Page-Disability Form $50
- Disability Parking Placard Form $30
- General Forms $50
- Notary $6

All disability forms require a recent office visit and examination within 2 months of the request.

Reminder: If your insurance requires a **referral number**, it is patient's responsibility to acquire one from their primary care physician. **Otherwise, appointment will be rescheduled.**

Appointment Policy:

We require a 24 hour notice for appointment cancellation/reschedule required* Not showing up for an appointment without proper notice will result in a $25 fee due to the office before rescheduling.

After **2** ***no-shows***, patient will be dismissed from our practice.

Must Provide Insurance Card/Identification for every visit! No Exceptions!

*If you do not have your insurance cards with you, your appointment will be rescheduled. **Copies are not accepted!**

Signature_____ **Date**_____

MEDICAL RECORDS RELEASE AUTHORIZATION

I,_____, hereby authorize you to release my medical records, by fax or mail, including copies of clinical notes, and lab/diagnostics results to the following:

Dallas Neuroscience, P.A.

1001 Robbie Mince Way Desoto, TX 75115

Phone: (214) 622-6300 FAX: (214) 622-6310

I understand and agree that:

- *This authorization is voluntary.*
- *Records obtained will be for the continuation of care.*
- *This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying Dallas Neuroscience, P.A. in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.*

_____

Signature

_____

Printed Name

_____

Date of Birth

_____

Date