PROFESSIONAL REHABILITATION ASSOCIATES, PSC

d/b/a **Integrity Diagnostics**

312 Jason Drive, Suite 5, Richmond, KY 40475

(859) 625-0001

(859) 625-1109 Fax

New Patient Information

Last Name:		First Name:
Middle Initial:	Date of Birth:	Social Security #:
Address:		Home Phone:
		Cell Phone:
Employer:		Sex:
Address:		Supervisor:
Occupation:		Work Phone:

Responsible Party/Card Holder Information

Last Name:		First Name:
Middle Initial:	Date of Birth:	Social Security#:
Address:		Home Phone:
		Cell Phone:
Relationship to Patient:		Work Phone:

Emergency Contact Information

Last Name:	First Name:
Relationship to Patient:	Home Phone:
Cell Phone:	Work Phone:

Injury

Is this injury related to: Automobile Accident: ☐ Worker's Compensation: ☐ Other:		
Describe Injury:		
Date of Injury/Onset:	Did you report the injury?	Date Reported:

I hereby authorize payment of medical benefits to Professional Associates, PSC for services rendered. I further authorize the release of medical information required to process an insurance claim on my behalf. I certify a copy of the authorization to be a valid original. All costs of services not paid for by my insurance will become my responsibility.

Patient Signature:	Date:
Responsible Party Signature:	Date:

Professional Rehabilitation Associates

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Integrity Diagnostics

Electrodiagnostic Testing Consent & Authorization to Test

Electromyography (EMG) and Nerve Conduction Testing (NCS) are diagnostic 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, muscles or the junctions 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 your 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 muscles and it may be repeated on several muscles. You also will 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 those with your referring physician or with your 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. acknowledge that I have had the procedures explained to me.

Patient Name: _____ Date: _____

Witness: _____ Date: _____

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Authorization for Release of Health Records and Reports

I, the undersigned, hereby authorize Professional Rehabilitation Associates, (PRA) d/b/a Integrity Diagnostics to release the following information of the health record(s) of the below named patient:

Patient Name: DOB: Phone:

Information to be released:

Electrodiagnostic Report: _____
Diagnostic Ultrasound Report: _____
Other (Specify): _____

Dates of Service: _____

Information to be Released To:

Name/Facility Address:

I understand that I have the right to revoke this authorization at any time except to the extent that PRA has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to PRA as identified in the Notice of Privacy Practices.

I also understand that when information is used or disclosed based on an authorization; the information may be re-disclosed by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information

I understand that I have the right to refuse to sign this authorization and that PRA will not condition treatment on the provisions of this authorization.

Patient Name: Date:

Witness: Date: