Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

PATIENT INFORMATION

Name_____

Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____

Social Security # _____Birthdate___/____/_____Age_____Sex_____

Spouse Name (or responsible party) _____

Spouse Social Security # _____Spouse's Birthdate_____/____/_____

In case of emergency notify:_____Phone_____

Marital Status: Single_____Married_____Divorced_____Widowed_____

Insurance Information

Primary Insurance Company_____

Name of Insured_____

Insured ID #_____

Secondary Insurance Company_____

Name of Insured_____

Insured ID # _____

Accident: Work_____Auto_____Personal Injury_____Date of Injury_____

Insurance Authorization and Assignment

I request that payment of authorized Medicare, Medicaid, Commercial Carrier, Workman's Compensation, or VA benefits on my behalf be made to Northwest Arkansas EMG Clinic for any services provided to me by Dr. Johnson. I authorize Dr. Johnson to release to the Health Care Administration and its agents any information needed to determine benefits payable for related services. I understand that I am responsible for any deductible, co-pay, or services not covered by my insurance carrier. I also authorize the physician to release any information required by my insurance company and/ or another physician.

_____ _____
Patient Signature or Legal Guardian (if minor) Date

Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

Patient Communication

You have the right to request that we communicate with you in confidence regarding your personal and health information.

There are several ways we may communicate with you or your legal guardian. They are as follows:

- Telephone to your home or workplace.
- Telephone answering machine.
- By mail
- By facsimile

Please indicate your preference for our communication to you regarding your personal health information.

☐ Telephone call to your home
☐ Telephone call to your place of employment
☐ Telephone answering machine
☐ Mail
☐ Facsimile

You may change your choice of communication regarding your personal health information at any time. Your request must be made in writing and submitted to our clinic to the attention of the medical records custodian.

Patient Signature or Legal Guardian Date

Witness Date

Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

Patient Name: _____

Height: _____Weight:_____Age:_____Date of Birth_____

Personal Physician: _____

Consultation & EMG Test Referred By:_____

Date of return visit to Referring Physician: _____

Please Circle all that apply:

Right or left handed:		Right	Left		
Main Problem Area:		Neck	Low Back	Right Arm	Left Arm
Right hand	Left Hand	Right Leg	Left Leg	Right Foot	Left Foot
Symptoms:	Pain	Numbness	Tingling	Burning	Weakness
Quality of Symptoms:		Mild	Moderate	Severe	

How long have you had symptoms? (be specific):_____

Are the symptoms you are having: Increasing Decreasing or No Change in Severity

Are the symptoms: Constant or Intermittent

Result of: Accident Injury Unknown

Are you pregnant? Yes No

Diabetes: □ No □ Type 1 □ Type 2 □ Insulin Dep. □ Oral Meds

Thyroid Disease: □ No □ Hypothyroidism □ Hyperthyroidism

Current Illnesses: _____

Have you had Spinal or Extremity Surgeries? (please list):_____

Medications: _____

Allergies to Medications:_____

Family History of Heart Disease, Cancer or Diabetes:_____

_____

Do you smoke? Yes ____ No ____ How Much _____

Do you drink alcohol ? Yes ____ No ____ How Much _____

Occupation type (be specific):_____

Exam (reserved for office use)

Neck _____ DTR's _____

Back _____ Extremity_____

Motor_____ Gait _____ Sensory _____

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Symptom Evaluation

Patient Name:_____

Please circle all that apply:

Constitutional:	Fever	Fatigue	Night Sweats	Weight Loss
HEENT:	Headaches	Diplopia	Swallowing problem	
Respiratory:	Cough	Hemoptysis (cough & blood)		
Cardiovascular:	Chest pain	Palpitations		
Vascular:	Claudication (calf pain with ambulation)			
GI:	Nausea	Vomiting	Diarrhea	Constipation
	Incontinence of bowel			
GU:	Incontinence of bladder			
Metabolic/Endocrome:	Generalized weakness	Heat/Cold intolerance		
Dermatology:	Rashes			
Muscloskeletal:	Joint pain	Muscle pain	Weakness	
Hemotologic:	Bruising/Bleeding			
Neurological:	Pain	Numbness	Tingling	Weakness
	Balance abnormalities	Vision change	Headaches	

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Financial Policy

This notice explains any financial information regarding payment of services performed by NWA EMG Clinic involving you, and any responsibilities our services will extend to any insurance company.

Insurance Coverage

If you have insurance coverage, you will be contacted by our billing office prior to the scheduled appointment date, if there is a deductible that must be met. You will be informed of an estimate of what will be your responsibility. You are expected to bring the full amount discussed. We will file a claim to the insurance company and any portion that the insurance does not cover will be your responsibility.

Workers compensation

If you have workers compensation we will be happy to file the claim for you. We must have all information necessary to file. If for some reason your work comp is denied, then the balance becomes your responsibility. If you wish us to file it to your commercial insurance, we must be informed by you with all the necessary information, otherwise the balance again becomes your responsibility.

Personal Injury or MVA

We will be happy to file any of these claims for you, if we have all the information necessary. If it is a third party claim you may be asked to help us in the process of retaining information. If we do not get all the information needed then the balance will be your responsibility until we get the necessary information. Also, we will send you a monthly statement to remind you of your balance with us. If a settlement is reached and the payment is sent to you, then you will be responsible to pay us the balance on your account.

Medicaid

If for some reason Medicaid denies payment on any portion of our services,
then we will file an extension of benefits as a courtesy to you. Then, if the extension is denied, the remaining balance is your responsibility.

Allowable forms of payment:	Cash, check, money order, or credit card.
Insufficient funds charge:	There will be a $25.00 charge for any insufficient funds check.

We appreciate you taking the time to read this information and will be happy to discuss any aspect of our financial policy. If you have any questions please let us know.

Patient Signature:_____Date_____

I hereby acknowledge that I have been presented with a copy of "Northwest Arkansas EMG Clinic Notice of Privacy" policy.

Patient Signature_____Date_____

Northwest Arkansas EMG Clinic
Notice of Privacy Policy

Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home, rather than your work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound to our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and to obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **The Privacy Officer @ Northwest Arkansas EMG Clinic. There will be a $5.00 charge for the medical records requested by the patient and should be paid at the time of the request.**

You may ask to amend your health information if you believe it is incorrect or incomplete, as long at the information is kept by, or for our practice. To request an amendment, your request must be in writing and submitted to: **The Privacy Officer @ Northwest Arkansas EMG Clinic.** You must provide us with a reason that supports your request for amendment.

Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **The Privacy Officer @ Northwest Arkansas EMG Clinic.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact:

Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.
c/o The Privacy Officer
PO Box 9450
Fayetteville, AR 72703