ROBERT HALL MD LLC

PATIENT INFORMATION: **(PLEASE PRINT CLEARLY)**

FIRST NAME:_____ MI: _____ LAST: _____

ADDRESS:_____APT:_____

CITY: _____STATE: _____ ZIP: _____

PHONE: (_____) _____-_____ BIRTHDATE: _____/_____/_____ GENDER: MALE FEMALE

CELL PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____

E-MAIL: _____

SOCIAL SEC NUMBER: _____ MARITAL STATUS (CIRCLE): S M D W SEP.

RACE (CIRCLE): CAUCASIAN * AFRICAN-AMERICAN * ASIAN * AMERICAN INDIAN * OTHER_____

ARE YOU CURRENTLY A RESIDENT OF A NURSING HOME OR SKILLED NURSING FACILITY? ___ YES ___ NO

EMPLOYMENT INFORMATION:

STATUS (CIRCLE ONE): FULL TIME PART TIME NOT EMPLOYED RETIRED STUDENT

EMPLOYER NAME: _____ OCCUPATION:_____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

VISIT INFORMATION:

FAMILY DOCTOR: _____ PHONE: (_____)_____-_____

REFERRING DOCTOR: _____ PHONE: (_____)_____-_____

REASON FOR VISIT: _____

PRIMARY INSURANCE: (Please present your insurance cards and photo ID for copying)

NAME OF INSURANCE: _____

ID NUMBER: _____ GROUP NUMBER: _____

NAMED OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____/_____/_____ SSN: _____ EMPLOYER: _____

SECONDARY INSURANCE **If no secondary insurance, initial here:_____**

NAME OF INSURANCE: _____

ID NUMBER: _____ GROUP NUMBER: _____

NAMED OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____/_____/_____ SSN: _____ EMPLOYER: _____

AUTO ACCIDENT INFORMATION (If applicable):

DATE: _____ CITY, STATE OF ACCIDENT: _____

SHOULD BILL BE SENT TO AUTO INSURANCE OR PATIENT? _____

IF INSURANCE, PLEASE LIST AUTO INSURANCE AGENCY, ADDRESS AND PHONE:

AUTO INSURANCE: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE: _____

AUTO CLAIM NUMBER: _____

WORKER'S COMPENSATION INFORMATION (If applicable):

CLAIM NUMBER: _____ DATE OF INJURY: _____

PHYSICIAN OF RECORD: _____ PHONE: (_____) _____-_____

EMPLOYER AT TIME OF INJURY: _____ PHONE: (_____) _____-_____

MCO NAME: _____ PHONE: (_____) _____-_____

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PERMISSION TO LEAVE MESSAGES

BEFORE WE CAN LEAVE A MESSAGE FOR YOU, WE MUST HAVE YOUR PERMISSION:

	LEAVE MESSAGE?		OTHER PERSONS WE MAY SPEAK TO:
HOME PHONE: _____	YES	NO	_____
CELL PHONE: _____	YES	NO	_____
WORK PHONE: _____	YES	NO	_____

ALL PATIENTS MUST READ AND SIGN BELOW

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT:
I have been provided an opportunity to review and receive the Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice for Robert Hall MD LLC. Through this notice I have been informed of my privacy rights with respect to my Protected Health Information (medical records and other personal health information.)

PAYMENT AND REFERRAL AGREEMENT:
I request that payment of authorized benefits be made either to me or on my behalf to Robert Hall MD LLC. I authorize the release of my medical information to a third party payor including the Health Care Financing Administration for the determination of benefits or benefits payable for services rendered**. I agree to be fully responsible for all lawful debts incurred by myself for services received whether covered by insurance or not. I certify that all needed prior authorizations have been secured and understand that if such authorizations are not secured, the charges will be my responsibility.**

Signature: _____ Date: _____

EMG Questions

Patient name: _____

Date of birth: _____

1. What symptoms are you having? Pain Numbness Tingling Weakness
2. On which side of your body are you having symptoms? Right Left Both
3. Where are your symptoms **mostly** located? Hand Arm Shoulder Neck
   Foot Leg Knee Hip Low back
   Other _____
4. When did your symptoms begin? _____
5. What activities make your symptoms worse? _____
6. Which of these surgeries have you had? Carpal tunnel Shoulder Neck Hip Knee Low back
7. Do you have diabetes (high blood sugar)? Yes No
8. Are you taking any blood thinners? Yes No
9. When is your next appointment with the doctor or nurse who ordered your EMG? _____
10. Do you have any questions about the EMG test? Yes No

Please read the following and sign before your EMG test.

I understand that my healthcare provider (doctor or nurse practitioner) has ordered an EMG test to help determine the cause of my symptoms. While EMG tests are safe, they do involve small electrical stimulations and needle sticks that may result in symptoms including, but not limited to, temporary discomfort, dizziness, lightheadedness, nausea, bruising, or a small amount of bleeding. The results of your test may or may not be discussed with you during your test today. However, any further testing or treatment for your symptoms will need to be discussed with the healthcare provider who ordered your EMG test.

Health insurance coverage varies depending on your insurance plan(s). Depending on your yearly deductible and out-of-pocket maximum payments, you may be required (by your insurance company) to pay all or part of the costs associated with your EMG test. Unfortunately, payments from HCAP cannot be accepted. Please feel free to ask if you have questions about eligibility for a discount (based on economic hardship) or a payment plan for any remaining costs to you.

Signature: _____ Date: _____