Oklahoma Spine and Musculoskeletal Medicine
Jonathan Stone, DO
Phone: 405-601-5899   Fax: 405-601-5903
www.oksmm.com

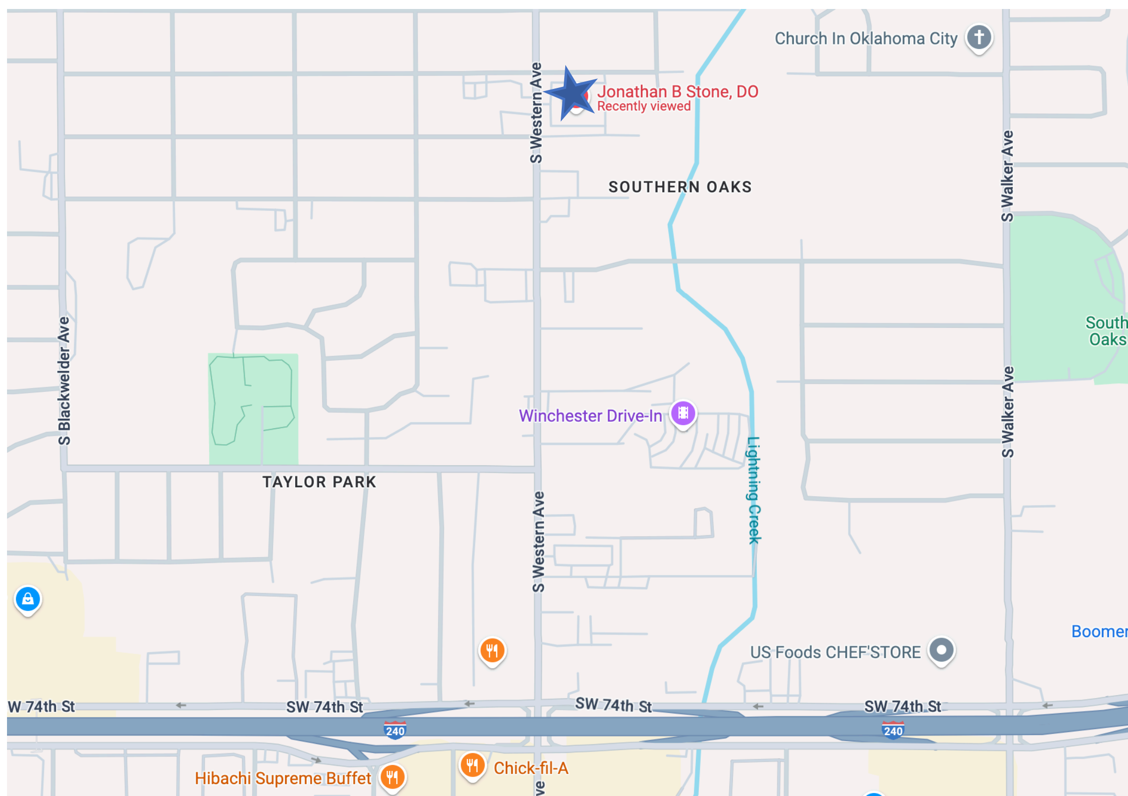
EMG and/or NCS

At the time of an EMG appointment, the patient's skin should be dry and clean without lotions, oils or creams. Wear loose and comfortable clothing on the day of the test.
The patient can take all medications as prescribed by his or her physician. There are no after effects of the EMG test and the patient can return to his or her usual activities immediately upon leaving.

Date:_____________________________ Time:_______________Check-in Time:_________________
This appointment has been reserved for you. ***Please give 24 hour notice if you cannot keep this appointment*.**

Testing will take place at:
Oklahoma Spine and Musculoskeletal Medicine
6510 S. Western Ave, Suite 102
Oklahoma City, OK 73139

Our new office space is located at Western Medical Park in **Building 100** behind Back and Posture Clinic of Oklahoma. The **Suite 102** entrance is at the northeast corner of the building. There is ample parking in the lot near the entrance.



What is an EMG?

EMG testing is a diagnostic examination of the peripheral nervous system, which includes nerve and muscle functions. The EMG test includes the nerve conduction studies and muscle needle examination. The nerve conduction studies are performed by placing electrodes on the skin, over certain nerves and muscles, and recording the responses when electrical impulses are applied to the nerve. The muscle needle examination involves direct recording of the muscle activity at rest and during contraction by inserting a small needle electrode into various muscles. The patient can take all medications as prescribed by his or her physician. There are no after effects of the EMG test and the patient can return to his or her usual activities immediately upon leaving.

What will happen during my EMG?

- Generally, it is more conducive for a more efficient study if there are no other people in the room except for the physician and the patient during the EMG.
- There are no after effects of the EMG test and the patient can return to his or her usual activities immediately. Sometimes small hematomas might form under the needle insertion points which are lumps or bumps. If you notice any of these, pushing down on them for 15-20 seconds usually takes care of them.
- At the time of the EMG appointment, the patient's skin should be dry and clean without lotions, oils or creams.
- Wear loose and comfortable clothing the day of the test. If your test is on the upper extremities, a short-sleeved shirt or tank top is recommended. Shorts are recommended for a test on the lower extremities.
- During the EMG, small needles are inserted into the muscles to measure electrical activity. The needles are different than needles used for injection of medications. The needles are small and solid, not hollow.
- You will be asked to contract your muscles by moving a small amount during the testing.
- Small electrodes will be taped to your skin or placed around your fingers. You will experience a mild and brief tingling or shock, which may be a bit unpleasant.
- Muscle activity is monitored through a speaker during the test, which may make a popping or soft roaring noise. This is normal.

After the procedure

Our physician will explain and go over the preliminary results with the patient right after the completion of the EMG. A copy of the EMG report will be sent to your referring physician 1-2 days after the EMG is completed.

We will process claims for services with your insurance carriers. You will be asked to pay copays, deductibles at the time of your visit. You can access your results and billing information on our patient portal at www.oksmm.com.

NEW PATIENT INFORMATION

Today's date: Primary Care Provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( ) ☐ Check Preferred
P.O. box:	City,State,Zip:	Cell Phone no.: ( ) ☐

Occupation:	Employer:	Employer phone no.: ( )	May we send you text messages? Yes ☐ No ☐

Email address:

Language other than English: Race: Ethnicity:

Chose clinic because/Referred to clinic by (please check one box): Text ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Preferred Pharmacy:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

THIRD PARTY BILLING

Is your injury work related? ❑ Yes ❑ No Is this injury due to an accident? ❑ Yes ❑ No If your injury is MVA related, have you obtained an accident report? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the physician or insurance company to release any information required to process my claims. I acknowledge and agree that I have received a copy of the OSMM Privacy Notice.

Patient/Guardian signature *Date*

OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE, PLLC
Jonathan B. Stone, D.O. - Physical Medicine & Rehabilitation
6510 S Western Ave., Suite 102, Oklahoma City, OK 73139
Phone: (405) 601-5899 Fax: (405) 601-5903

Authorization to Release Medical Information

Patient Name: ______________________________ Date of Birth: ______________________

Social Security # ______________________________ Telephone #: ______________________

I am the _____ Patient, _____ Guardian, _____Parent of Minor Child, _____ Personal Representative and hereby authorize

______________________ personnel to disclose medical information on the above named patient to:

Jonathan B. Stone, D.O.
6510 S Western Ave., Suite 102
Oklahoma City, OK 73139
Fax: (405) 601-5903

Purpose of Request: _____Patient Request _____ Referral _____Other: ______________________

Dates of treatment: ____

Information Requested: (Copies will be provided at $1.00 for first page and $0.50 per additional page)

☐ Radiology Reports	☐ Physicians Orders	☐ Complete Medical Record
☐ Radiology Films	☐ Progress Notes	☐ Other ____________
☐ Laboratory Reports	☐ Dictated Reports	________________

I understand:

- I may revoke this Authorization at any time by sending a written request to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be 12 months from the date of my signature.
- If I do not sign this form, my health care and the payment for my healthcare will not be affected unless stated otherwise.
- **The information authorized for release my include records that may indicate the presence of a communicable disease or noncommunicable disease.**
- The information authorized for release may include drug/alcohol abuse treatment records protected under the Code of Federal Regulations and psychiatric records. Re-disclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization. If the records are psychiatric in nature, the attending physician must consent to the release of medical records.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

______________________________ ______________________
Signature of Patient, Parent, Personal Representative Date

____
Relationship to Patient

____
Witness

OKLAHOMA SPINE ANE MUSCULOSKELETAL MEDICINE
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

AUTHORIZATION FOR TREATMENT

I hereby authorize Dr. Jonathan B. Stone, D.O. to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Dr. Jonathan B. Stone, D.O. of the medical insurance benefits otherwise payable to me for services rendered during my visit at OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE. I understand I am financially responsible for charges not covered by this assignment.

MEDICAL INFORMATION RELEASE

I authorize the physician to release any medical information required to process this claim.

CONSENT TO CALL

I authorize my provider's office to contact my by telephone to remind me of my appointments.

MEDICATION HISTORY

I authorize my provider's office to access and download my medication history from pharmacy benefit managers.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Oklahoma Spine & Musculoskeletal Medicine Notice of Privacy Practices.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE and its physicians from any claim for responsibility or damages in the event of loss of my property, including, but not limited to, money, cell phone, or jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED: ____ **Date:** ____________
(Patient)

OR ___________________________________ Witness to Signature: ________________
(Nearest relative or responsible party)

______________________________ Policyholder's Signature: ______________________
(Relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court, or to the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is release, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

OKLAHOMA SPINE ANE MUSCULOSKELETAL MEDICINE
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

OFFICE FINANCIAL POLICY

We would like to thank you for choosing Dr. Jonathan Stone as your doctor. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

PAYMENT

Payment is expected at the time of service. This is an insurance company rule. This includes co-payments or coinsurance for participating insurance companies. OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE, accepts cash, personal checks, and most credit cards. There is a service charge of $25 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

INSURANCE

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.

CANCELED APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $100 for appointments that are not canceled at least 24 hours in advance.

PAST DUE ACCOUNTS

If we have to turn your account over to collection, you may be charged 5% interest on the outstanding balance from the date your bill was due, and you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.

MOTOR VEHICLE ACCIDENT

If your injury was due to a Motor Vehicle Accident you will be set up on a self-pay account for any charges incurred up to $500.00. If charges exceed $500.00, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician.

ADDITIONAL PAPERWORK

There is a $25.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion by cash or money order.

MORE INFORMATION

Please call 405-601-5899 if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

Again, thank you for allowing us to participate in your care.

Sincerely,
Jonathan B. Stone, D.O. & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: ____ Date: ______________________________
(signature of person financially responsible for payment)

Relationship if other than patient : ____

OKLAHOMA SPINE AND MUSCULOSKELETAL MEDICINE

Jonathan B. Stone, DO
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

REQUEST TO RESTRICT THE MANNER AND METHOD OF CONFIDENTIAL COMMUNICATION

PATIENT INFORMATION	
Name:	
Address:	Birth Date:
City, State, Zip	Telephone

I hereby request to receive confidential communications from OSMM regarding my health condition, care, treatement, appointments, and/or payments in the following manner and method (please check all that apply):

☐ At a telephone number other than my home number.
Alternate number is: ______________________________

☐ At a mailing address other than my home address.
Alternate address is: ______________________________
____

☐ Via email.
email address: ______________________________

☐ The following individuals may pick up my prescriptions, samples, appointment information and records. ______________________________
____

☐ Messages may be left concerning my care on the answering machine, voicemail, or with the following individuals: ______________________________
____

I understand that if OSMM agrees to provide me with confidential communications regading my healthcare via the above identified alternate manner and method, OSMM may condition agreement upon the following:

1. The receipt of information from me as to how payment for OSMM services will be handled.
2. The specification of an alternate address or other method of contact.

______________________________ ______________
Patient Signature Date