

FORM # 2

Ayse L. Lee-Robinson, M.D.
Electrodiagnostic Medicine and Rehabilitation Specialist, LLC
 10700 Montgomery Road, Suite 110 • Cincinnati, Ohio 45242
 Ph: (513) 489-8000 • Fax: (513) 247-2782

Billing and Consent Sign-In Form**Patient Information:**

Date ____/____/2009

M / F

Name (Last, First, M.I.)	Date of Birth	Social Security #	Sex
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Address	City	State	ZIP
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Home Phone	Work Phone	Patient Employer	Occupation
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Referring Physician	Emergency Contact / Phone # (someone other than household member)
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Reason for today's visit:

RESPONSIBLE PARTY INFORMATION: (IF DIFFERENT FROM ABOVE)**M / F**

Responsible Party's Name (Last, First, M.I.)	Date of Birth	Social Security #	Sex
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Address (if different than patient)	City	State	ZIP
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Home Phone	Work Phone	Relationship to Patient	Employer / Occupation
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PRIMARY INSURANCE INFORMATION:

Primary Carrier	Address	Phone No.
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Policy #	Group#	Effective Date	CoPay Collected?	Amount / Initials of staff
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SECONDARY INSURANCE INFORMATION:

Secondary Carrier	Address	Phone No.
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Policy #	Group#	Effective Date	CoPay Collected?	Amount / Initials of staff
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Bureau of Workers Compensation (BWC Information: (Please complete if this is work related):

BWC Claim #	Date of Injury	Type of injury (pulling/pushing/lifting/etc.)	Physician of Record
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Managed Care Organization handling claim / Contact Person / Telephone # / Copy of C-9 attached

Claim allowed for diagnosis Code _____ Diagnosis _____

Code _____ Diagnosis _____

BWC Pal Line Called Yes / No Code _____ Diagnosis _____**CO-PAYMENT DUE: YES / NO IF YES COLLECTED \$ _____ in cash / credit / check****COLLECTED BY: _____ DATE OF COLLECTION: DOS OR ____ / ____ / 2009**TURN OVER TO PG. 2 

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Consent and Acknowledgement for Outpatient Treatment/ Diagnosis

I wish to be treated at Electrodiagnostic Medicine & Rehabilitation Specialists, LLC (EMARS) by Ayse L. Lee- Robinson, M.D. I permit EMARS/ Dr. Lee- Robinson, and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include diagnostic procedures, including needle EMG and nerve conduction studies and outpatient medical treatments. No guarantees have been made to me about the outcome of this care.

Consent to Reporting Medical/Health Information to your Doctor(s)

I permit EMARS staff and/or Ayse L. Lee- Robinson, M.D. to confidentially report the medical and health information gathered from this evaluation to my doctor(s).

Acknowledgement of Office HIPPA Policies

EMARS has written Notice of Privacy Practices and Office Privacy Policies as required by HIPAA. I am aware that these are available for my review at the office and I will be given copies of these practices and policies upon request.

X _____
Patient signature **Date**

The patient is unable to consent because: _____

I therefore consent for the patient _____
Signature **Relationship to patient**

Witness Signature **Date**

Authorization to File Insurance

I hereby authorize EMARS to release all medical information available, including the diagnosis and the records of any treatment or examination rendered to me, to the HealthCare Financing Administration, and any other third parties applicable during the period of medical care received by EMARS physicians.

X _____
Signature of patient or authorized person / **Date**

Assignment of Benefits

I hereby request that payment be made directly to EMARS. I understand that in consideration of the services to be rendered, I am responsible for payment of any services that are not covered by my insurance or from charges that arise because of inaccurate insurance information submitted.

UNDERSTAND THAT IF A REFFERRAL (HMO/PPO) IS NOT AT THE TIME OF MY VISIT, I WILL BE RESPONSIBLE FOR PAYMENT OF THE SERVICES RENDERED.

Our office will file insurance for your medical visits. There is a minimum of \$150.00 fee due at the time of service for initial PM&R consultations/evaluations and EMG/NCS testing. There is a minimum of \$60.00 due for reevaluation appointments for self-pay accounts.

X _____
Signature of patient or authorized person / **Date**