

Precision Medical Group, Inc.

AUTHORIZATION FOR AND CONSENT TO ELECTROMYOGRAPHY/NERVE CONDUCTION STUDY AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

My signature on this form indicates that: (1) I have read and understood the information provided in this form; (2) I have been provided with the opportunity to ask and receive answers to any questions I have about the Procedure; and (3) I authorize and consent to the performance of the Procedure by Precision Occupational Medical Group, Inc. (POMG) physicians/staff.

Electromyography (EMG)

Electromyography (EMG) is a diagnostic procedure to assess the health of muscles and the nerve cells that control them (motor neurons). EMG results can reveal nerve dysfunction, muscle dysfunction or problems with nerve-to-muscle signal transmission.

Motor neurons transmit electrical signals that cause muscles to contract. An EMG uses small needle electrodes to translate these signals into graphs, sounds or numerical values that are then interpreted by a specialist.

During the procedure, a needle electrode is inserted directly into selected muscles and records the electrical activity of those muscles. The skin is cleansed with an alcohol wipe and then the needle is inserted into the relaxed muscle to be evaluated. You may feel a pinch or a sting as the needle is inserted through the skin. When the needle is inside the muscle you may feel a pressure or discomfort. The test will record nerve/muscle activity and can be heard as static on the EMG machine. You will be asked to tighten your muscles to also evaluate them at work.

EMG is a generally low-risk procedure and serious complications are extremely uncommon. Common side-effects include local pain, bleeding and/or bruising at the site of needle insertion. Serious complications such as infection or nerve injury are rare.

Nerve Conduction Study

A nerve conduction study (NCS), also called a nerve conduction velocity (NCV), measures how fast an electrical impulse moves through your nerve. It can identify nerve damage. During the test, your nerve is activated using a stimulator device. The resulting electrical activity is recorded by an electrode. This is repeated for each nerve being tested. The amount of the electrical current is always kept at a safe level. You will feel a tingling sensation and your muscles will twitch as the current flows thru. The test will not harm you but may be uncomfortable. Common side-effects include brief discomfort at the sites of stimulation.

Certain factors or conditions may interfere with the test. As a precaution, please inform your physician if you are pregnant, on blood-thinner medication, have an infection, are on chemotherapy, or have a cardiac pacemaker/defibrillator.

There will be no restrictions on your activity after the tests. You may experience some minor aches or discomfort. If so, take it easy that day. If you notice any excessive bruising/bleeding, or signs of infection such as redness, warmth, swelling, pain, drainage or fever > 101 degrees F,

please call your physician immediately.

Authorization and Consent

1. I have been informed and acknowledge that I am free to obtain an EMG and NCS from the provider of my choice. I have decided that I would like to have the EMG and NCS performed by POMG.
2. I hereby authorize and direct POMG physicians/staff to perform the EMG and NCS (the "Procedure") and to perform any other diagnostic procedure and therapeutic procedure that their judgment may dictate to be advisable in case of emergency.
3. I acknowledge that POMG physicians/staff have fully explained to me the nature and purpose of the Procedure and that the Procedure may involve calculated risks of complications and injury from both known and unknown causes, including but not limited to bruising, bleeding, nerve damage, worsening pain, or infection. I acknowledge that no warranty or guarantee has been made as to the results or cure regarding any ailment I may have. I acknowledge I have been informed of the nature and purpose of the Procedure, the expected benefits, the risks of the complications, and the alternative methods of treatment, if applicable.
4. I recognize that I have the right to consent to or refuse the proposed Procedure after consultation with POMG physicians/staff. Further, I recognize that this form is not intended to be a substitute for the explanations of the nature and purpose of the procedure, the expected benefits, the risks of complication, and the alternative methods of treatment, if applicable, which have been explained to me by POMG physicians/staff.
5. I hereby authorize and direct POMG to provide such additional services for me as deemed reasonable and necessary.
6. I hereby authorize POMG to release my medical records to my referring doctor. Your EMG/NCV report will be forwarded to your referring physician within 72 hours. Your referring physician will go over the test results with you and should be able to provide you a copy of your report, upon request. If you would like a copy of your EMG/NCV report sent directly to you from our office, please call our office 72 hours after the date of service.
7. I may choose to have POMG's on-site assistants help fill out my patient intake forms. I acknowledge that, depending on circumstances, this conversation may or may not be private and confidential, and that by so requesting assistance, I waive any confidentiality protection related to my personal health history. I understand that if I do not wish to waive these rights, I can complete the patient forms without POMG assistance. (NOTE: The below paragraph does NOT apply if you are a workers' compensation patient.) I understand, acknowledge and agree that I am financially responsible for any portions of the fees for services not paid for by my insurance company, including my deductible, co-insurance and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior

approvals, pre- authorizations and second opinions, and that my failure to fully comply with my insurer's requirements may result in the denial of the claim(s) related to the services being provided, and in such instance I am fully responsible to pay.

I HAVE READ THE ABOVE AUTHORIZATION AND ACKNOWLEDGEMENT AND IT HAS BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS FORM, THAT I HAVE BEEN PROVIDED THE OPPORTUNITY TO ASK AND RECEIVE ANSWERS TO ANY QUESTIONS I HAVE CONCERNING THE PROCEDURE, AND THAT I AM COMPETENT TO EXECUTE THIS CONSENT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Doctor that is performing the test:

I understand and consent to the performance of the Procedure by [DOCTOR WRITTEN BELOW] and those under his immediate responsibility and supervision.

Name of doctor performing EMG/NCV test.

Name:

First (please print)

Last (please print)

Today's date: _____

Phone: _____

Email: _____

Signature: _____