RISE DIAGNOSTICS

Covid screening

Patent's Name:_____ DOB_____

Todays Date _____

In the past 24 hours, have you experienced:

Fever [ ] Y [ ] N

New or worsening cough [ ] Y [ ] N

Shortness of breath [ ] Y [ ] N

Sore throat [ ] Y [ ] N

Been in contact with someone who has COVID 19 [ ] Y [ ] N

If you answer "yes" to the symptoms related to COVID 19 listed above you will need to be rescheduled.

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date

RISE DIAGNOSTICS

Patient Information

Patent's Name:_____ DOB_____

Address: _____
City _____ State_____Zip _____
Phone: _____ Cell:_____ text? [ ] Y [ ] N
Email Address:_____

Emergency Contact: _____ Phone # _____
Relationship _____

Referring Medical Provider _____

Is this related to a surgery, or injury? [ ] Y [ ] N
Is this a work related injury? [ ] Y [ ] N
If yes, Employer name _____Phone #_____
Adjuster's name_____ Phone #_____
What is the workers comp claim # _____ official date of injury_____

Was this related to an auto accident? [ ] Y [ ] N
If yes, Attorney Name and # and or car insurance agent _____
_____

Insurance or Cash Pay

[ ] Primary [ ] Secondary
Insurance Name: _____ Effective date: _____
ID#: _____ Plan #_____ Group #_____

[ ] Primary [ ] Secondary
Insurance Name: _____ Effective date: _____
ID#: _____ Plan #_____ Group #_____

_____ _____
Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____
Witness Signature Date

RISE DIAGNOSTICS

Medical History

Patient Name _____
Referring physician _____

Date of injury or when symptoms began _____

Briefly describe your injury/symptoms

_____

_____

Did you have surgery for the above injury or symptoms?
[ ] Y [ ] N
Are you presently taking any medication? [ ] Y [ ] N
If yes, Please list the name, condition and how long. If you have a list we can take a picture of it.

_____

_____

__High blood pressure
__Low Blood Pressure
__High Cholesterol
__Cancer
__Heart problems
__Latex Allery
__Diagnosed with diabetes
__Diagnosed with neuropathy
__Dizziness / Vertigo
__History of falls due to dizziness or unsteady gait
__Hypertension or Hypotension
__Blurred vision
__Hearing problems
__Easily fatigued

__Dramatic weight gain, or weight loss
__Lack of appetite
__Shortness of breath or coughing
__Heart palpitations
__Bowel or Bladder Incontinence
__Balance or coordination problems
__Depression or Anxiety
__Anemia or Blood Disorder
__Joint/Muscle Swelling
__Arm/Leg Swelling
__Weakness
__Fever/Chills/Sweats
__Difficulty Breathing
__Seizures

_____

_____

_____

Please describe all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury:

_____

_____

Do you smoke or drink alcohol? Quantity? _____

_____ _____
Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____
Witness Signature Date

RISE DIAGNOSTICS

Pain Assesment

Patient Name _____

Referring physician _____

What words best describe your pain?

__ Aching
__ Cramping
__ Burning
__ Shooting
__ Throbbing
__ Pressure
__ Electric shock
__ Gnawing
__ Deep aching
__ Hot
__ Itching
__ Squeezing
__ Stabbing
__ Tingling
__ Other

Please describe your pain: Numbness, or weakness. Where does it originate, how far does it extend?

_____

_____

How long have you been experiencing your pain symptoms? _____

Are your symptoms occasional? If so, how often? _____

Are your symptoms constant? _____

If applicable, please select all symptoms that you are experiencing:

__ Low back pain
__ Neck pain
__ Burning sensation
__ Sensation of pins and needles
__ Overall muscle weakness
__ Numbness in the arms
__ Weakness in the arms
__ Radiating pain in arms
__ Numbness/ tingling in hands
__ Loss of sensation or decreased sensation in hands
__ Weakness in hands
__ Numbness in legs
__ Weakness in legs
__ Radiating pain in the legs
__ Numbness/tingling in the feet
__ Loss of sensation or decreased sensation in feet

Does your pain disturb any of the following?

__ Sleep
__ Walking
__ Concentration
__ Relationships
__ Eating
__ Housework
__ Energy
__ Enjoyment of life
__ Self-care
__ Work
__ Mood
__ Recreation
__ Lifting
__ Gripping

What have you tried to treat the pain?

_____

_____

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

RISE DIAGNOSTICS

Informed Consent for EMG and NCS

Electromyography Laboratory Authorization & Consent for Testing

Electromyography (EMG) and Nerve Conduction Testing (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscles or the junctions between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of the body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscles and it may be repeated on several muscles. You will also be asked to contract your muscles during the EMG.

There are certain inherent risks with EMG/NCS. During EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory tests and muscle biopsies. There may also be other risks depending on your medical condition; please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock-like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risks depending on your medical condition; please discuss those with your referring physician or with your electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedure explained to me.

I agree to hold Rise Diagnostics harmless for claims or damages in connection with treatment. This is a contract between myself and Rise Diagnostics, and I understand that it is also a release of potential liability.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date

RISE DIAGNOSTICS

Financial Policies

I _____ am responsible for the payment of all charges associated with my visit. As a courtesy, and for my convenience, Rise Diagnostics will bill my insurance company when I have provided my insurance information. I am responsible for deductibles, co-payments, co-insurances, and uncovered services at the time services are rendered. I am responsible for contacting my insurance carrier if I am unsure of my coverage. If the insurance payment is not received within 60 days of billed charges, I am immediately responsible for the full account balance.

All co-payments, deductibles, and/or co-insurance are due at the time of service.

If proof of insurance cannot be provided, patient will be deemed “self-pay”, and payment will be due in full at the time of service.

Private insurance is a contract between you and your insurance company. Rise Diagnostics will not be involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, “usual and customary” charges, etc. Rise Diagnostics will supply information as necessary.

If the patient is a minor, in the case of separation or divorce, the parent bringing the minor in for their appointment is responsible to pay for services.

Any balances on your account must be paid in full before you will be seen again, unless payment arrangements have been made with the billing department.

A fee of $35 will be charged to the patient for any returned checks marked for NSF. The patients account will be flagged until the debt has been paid. Payment must be made by cash, credit card, or money order.

Methods of payment accepted: cash, personal checks, Visa, and MasterCard.

Cancellation/ No Show Policy: If you No Show or need to cancel your scheduled appointment, a 24-hour notice must be given or a fine of $25.00 will be charged and will be due upon your next visit.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date

RISE DIAGNOSTICS

HIPPA Privacy Policy

I, _____ acknowledge that I have been provided the HIPAA Notice of Privacy Practices by Rise Diagnostics. I acknowledge that the HIPAA Notice of Privacy Practices describes the use and disclosure of my protected health information (PHI), and identifies my rights and the duties of which Rise Diagnostics must uphold.

1. Use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPHO).
2. Call my home or other designated locations to speak in person or leave a voice message about any items that assist the practice in carrying out TPHO. Including, but not limited to: appointment reminders, insurance items, my clinical care, and diagnostic results.
3. Send mail to my home or other designated location any items that assist the practice in carrying out TPHO. Including, but not limited to: appointment reminders, patient statements, and insurance items.
4. I have the right to request that Rise Diagnostics restrict how my PHI is used and/or disclosed to carry out TPHO. However, the practice is not required to agree with my requested restriction, but if they do, they are bound to this agreement.
5. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Rise Diagnostics may decline to provide treatment to me.

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to be released to the following:

Other: _____

[ ] Information is not to be released to anyone

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date

RISE DIAGNOSTICS

Practice Policies

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for testing is 120 minutes.

A $35 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. All existing confidentiality protections are equally applicable.
Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

MINORS

If you are a minor, your parents may be legally entitled to some information about your treatment. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Patient Signature (Parent/ Legal Guardian if patient is a minor) Date

_____ _____

Witness Signature Date