REGIONAL HEALTH DIAGNOSTICS, INC.

EEG QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE CONCERNING YOUR EEG TEST

NAME: _____ AGE: _____

DATE OF BIRTH: _____ SOC SEC #:_____

HEIGHT: _____ WEIGHT: _____ HANDEDNESS: R L

WHAT IS YOUR CHIEF MEDICAL COMPLAINT?

_____

_____

LIST ALL MEDICAL ILLNESSES:

_____

_____

LIST YOUR CURRENT MEDICATIONS:

_____

_____

_____

DRUG ALLERGIES? YES NO
IF YES, PLEASE LIST: _____

HISTORY OF STROKE? YES NO
IF YES, DATE OF STROKE:_____

ARE YOU DIABETIC OR REQUIRE A SPECIAL DIET? _____

HOW DO YOU FEEL TODAY? _____

IN CASE OF EMERGENCY

Name: _____ Relationship to Patient:_____

Day Phone # ( )_____ Evening Phone # ( )_____

REGIONAL HEALTH DIAGNOSTICS, INC.

TUBERCULOSIS QUESTIONNAIRE

In accordance with federal regulations, we are required to ask you the following questions in order to possibly protect you and other patients from exposure to tuberculosis.

Patient Name: _____

Date: _____

Have you had a cough for 3 weeks or longer?	Yes	No
Have you coughed up blood during this time frame?	Yes	No
Have you had night sweating that leaves sheets/bed clothes wet?	Yes	No
Have you lost weight for unknown reason?	Yes	No
Have you had a fever for greater than one month?	Yes	No
Have you been exposed to anyone with tuberculosis?	Yes	No

If yes, when _____relationship_____

PLEASE PROVIDE ALL THE INFORMATION REQUESTED ON THIS FORM.

THANK YOU.

REGIONAL HEALTH DIAGNOSTICS, INC

1. **General Consent for Treatment:**
   This is to certify that (we) the undersigned, voluntarily consent to the administration and performance of diagnostic procedure/imagining/photography and medical treatment by authorized agents and medical treatment by authorized agents and employees of the nearest hospital to Regional Health Diagnostics, Inc. and its medical staff or their designees, as may, in their professional judgment, be deemed necessary or beneficial. Unless I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.

2. **Authorization to Release Medical Information:**

   I (we), _____, the patient/legal representative of
   Print (Patient/Parent(s) or Legal Representative

   _____, hereby authorize Regional Health
   Print (Patient name)
   Diagnostics, Inc. to release the medical records and/or other information, including copies, concerning this treatment commencing on _____ to the following for the purpose of
   Date of service
   obtaining and processing claims for payment of medical expenses incurred:

   a. Government agencies or programs, managed care organizations and/or insurances companies.
   b. The utilization review organization contracted by my employer, insurance company or governmental agency or program, or to Physicians or other health care institutions responsible for further care or follow up treatment to serve the goal of continuation of my care. The authorization includes the follow-up treatment to serve the goal of continuation of my care. The authorization includes the release of medical records and/or information concerning drug abuse, drug related conditions, alcoholism, psychological, psychiatric conditions, and/or communicable disease (including AIDS), if applicable.

I (we) understand this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This authorization will expire in three hundred sixty five (365) days after treatment.

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

3. **ASSIGNMENT OF INSURANCE BENEFITS:**
   I (we) hereby authorize payment directly to Regional Health Diagnostics, Inc. outpatient benefits otherwise payable to me including major medical insurance. I (we) also authorize surgical or medical benefits to be paid directly to any physician that renders service to or for me for which an assignment is applicable. I (we) understand that I (we) am/are financially responsible to hospital or physicians for charges not paid under this assignment.

4. **FINANCIAL AGREEMENT:**
   The undersigned agree, jointly and severally, whether they sign as guarantor or as patient, that in consideration of the services to be rendered to the patient, they do hereby guarantee payment to Regional Health Diagnostics, Inc. on demand for all charges for said services and incidentals incurred on behalf of such patient.
   The undersigned acknowledges that the account of Regional Health Diagnostics, Inc. does not have to include services of doctors treating or furnishing services to the patient, including, but not limited to, the radiologist, anesthesiologists, emergency room physicians, pathologists and the like, and that the patient may expect to receive a separate statement or account from/for each such physician.

5. PERSONAL VALUABLES:

Regional Health Diagnostics, Inc. encourages the patient to not bring any valuables (cash, jewelry) and extra clothing. Regional Health Diagnostics, Inc. will not be responsible for any personal items that the patient keeps in his/her possession while he/she is here. All items, including but not limited to clothing, eyeglasses, dentures, hearing aids or electronic devices, which remain in your possession are not the responsibility of Regional Health Diagnostics, Inc.

DATED THIS_____ DAY OF _____, 20_____, THE UNDERSIGNED CERTIFIES THAT I (WE) HAVE READ THE FOREGOING AND HAVE RECEIVED A COPY THEREOF, AND FURTHER UNDERSTAND THAT I (WE) AM LIABLE TO REGIONAL HEALTH DIAGNOSTICS, INC UNDER THE FINANCIAL PROVISIONS HEREIN ABOVE STATED.

_____ _____

PARENT OR LEGAL REPRESENTATIVE GUARANTOR/RELATIONSHIP

_____ _____

PATIENT SIGNATURE WITNESS

Regional Health Diagnostics, Inc.

As of April 14, 2003, Regional Health Diagnostics, Inc., in compliance with the HIPAA Privacy Rule, has drafted a Notice of Patient Privacy Practices. Your signature here acknowledges that you have been made aware of this notice and a copy is available to you upon request.

Signature: _____ Date: _____

CONSENT FOR SPECIAL PROCEDURES

I, _____ authorize the performance of the following procedure(s), Extended Video EEG, Routine EEG, Ambulatory EEG, PSG, Split Night Study, MSLT, MWT or the administration of Oxygen as needed. I understand these procedures will be under the supervision of Khaled F. Jreisat, M.D., Medical Director.

The nature and purpose of the procedure, possible alternative methods of treatment, and risks involved and the possibility of complications have been fully explained to me. No guarantee of assurance has been given by anyone as to the results that may be obtained.

I understand the room itself is adapted for sleep environment and the bedroom environment is necessary to simulate, as near as possible a real life sleep situation. In the event of an emergency, it may be necessary for me to be transported by ambulance to the nearest hospital for definitive treatment.

I consent to the taking of videotape pictures with soundtrack during my nocturnal polysomnogram or extended or routine EEG recording as part of the diagnostic study by Regional Health Diagnostics, Inc.

I understand that the videotape will be used for diagnostic study and for the purpose of medical education. Any use of the tape for medical education purposes will not identify me by name and I consent to the use of the recording under these circumstances.

_____ _____

Patient Signature Witness Signature

_____

Date

ACHC Accreditation Commission for Health Care

25 Years of Excellence 1986-2011

Regional Health Diagnostics, Inc.

Client Consent for the Purpose of Treatment, Payment, Patient Bill of Rights, Privacy Policies, and

Health Care Operations, Grievance Policy and CMS Supplier Standards

I,_____ give consent to Regional Health Diagnostics, Inc. for the use and disclosure of my Protected Health Information for the specific purposes of providing treatment to me, receiving payment for services rendered to me, and for general administrative operations of the practice

_____ _____

Signature Date

I understand that I have the right to request restrictions on the use and the disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice.

I have received a copy of the Privacy Policies Notice, the Patient Bill of Rights, Patient Grievance Policy and the CMS Supplier Standards were disclosed to me prior to treatment. (CMS for Medicare recipients only) By signing below I am acknowledging that all the above mentioned policies/ standards were provided to me and explained.

_____ _____

Signature Date

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the practitioner in writing.

REGIONAL HEALTH DIAGNOSTICS, INC

ACKNOWLEDGEMENT OF RECEIPT

I (we) _____, the patient/legal representative,

Print (Patient/Parent(s) or Legal Representatives

acknowledge I have received a copy of Notice of Privacy from Regional Health Diagnostics. I (we) have read the Notice of Privacy and understand its contents.

_____ _____

Patient Signature or Legal Guardian or Representative Witness Signature

_____

Date