

Dr. Julia McCoy
Neurology of Arkansas
PO Box 16563 Little Rock, AR 72231

P: 501-993-3715
F: 866-816-9411

EMG-NERVE CONDUCTION TEST APPOINTMENT PAPERWORK

APPOINTMENT DATE: _____ TIME: _____

Appointment Information:

- Please arrive 10 minutes prior to your appointment with completed paperwork, insurance cards and driver's license.
- NOTIFY our office immediately if you need to cancel or reschedule appointment with 24 hours notice to avoid a cancelation fee.

EMG-NCV Testing Info:

- DO NOT wear any lotions, oil, creams, gels, or Vaseline on areas to be tested (i.e. legs, feet, arms, hands). Make sure your skin is clean and dry.
- Deodorant and make-up are fine to wear.
- No additional prep is required. You may eat, drink, take any medications as prescribed.
- Please indicate if you are taking a blood thinner or if you have a pacemaker or stimulator.

COVID Precautions:

- Notify our office immediately if you have become sick or have been exposed to COVID.
- Limit number of people to your appointment.
- Masks are optional at this time.

APPOINTMENT LOCATION:

**Bowen Hefley Orthopedics
4300 Landers Road
North Little Rock, AR 72117**

Please check in at front desk stating you are seeing Dr. McCoy for a Nerve Conduction Test.

THANK YOU!

PATIENT INFORMATION:

Full Name: _____

SSN: _____ Date Of Birth: _____ Marital Status: S M D W Sex: M F

Mailing Address: _____
City State Zip

Home Phone: _____ Cell # : _____ Email: _____

Place of Employment: _____ Phone: _____

Employer address: _____

Spouse Full Name: _____ SSN: _____ DOB: _____

Spouse Employer: _____ Phone: _____

Referred by: _____ Phone: _____

Nearest Relative / Friend Not living with you: _____ Phone: _____

Primary Doctor Name: _____ Phone: _____

Primary Insurance: _____ Phone: _____

Address: _____ Insured's Name: _____ DOB: _____

ID # : _____ Group # : _____ (Please bring card to appointment)

Secondary Insurance: _____ Phone: _____

Address: _____ Insured's Name: _____ DOB: _____

ID # : _____ Group # : _____ (Please bring card to appointment)

I authorize Neurology of Arkansas, PA (and any representative thereof) to release any and all information that is necessary to any insurance company or companies, to my referring physician, or physician to which I may be referred. I authorize payment of benefits direct to Neurology of Arkansas for services rendered and understand that I am responsible for any charges that are denied by my carrier. (If my coverage requires a referral from a primary care physician, I will be responsible for obtaining the necessary form and / or number. I understand that if I do not obtain the proper referral before coming to my appointment I cannot be seen.)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM :

I have received a copy of the Notice of Privacy Practices for Neurology of Arkansas, PA.

NOTIFICATIONS: I consent I do not consent: to SMS text messages from Neurology of Arkansas and affiliates. I am responsible for any fees that my mobile carrier's charges. I may notify Neurology of Arkansas in writing at anytime to withdraw my consent.

I consent I do not consent: to email notifications and communications from Neurology of Arkansas and affiliates. I may notify Neurology of Arkansas in writing at anytime to withdraw my consent.

Signature: _____ Date: _____

**NEUROLOGY OF ARKANSAS, PA
PATIENT MEDICAL HISTORY**

PATIENT NAME: _____ AGE: _____

General Information

Why were you referred for nerve testing with Dr. McCoy? **(Please be specific)**

Are you allergic to any medications? Please list: _____

Do you have or have you had any of the following? (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Neck Trouble | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Fainting/Blacking out | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Anxiety/Nervous Condition |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Jaw/Joint Pain |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Renal (Kidney) Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Exposure to AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypoglycemia (low blood sugar) |

Cancer, if so what kind: _____

Autoimmune Disorders, such as Lupus, Rheumatoid Arthritis, etc: _____

Family History of: Stroke, Parkinson's, Alzheimer's, ALS (Lou Gehrig's disease), other nerve or muscle disorders resulting in full or partial paralysis. (circle all that apply)

Other (please list): _____

REVIEW OF SYSTEMS

NEUROLOGIC:

- | | | | | | |
|-----|----|--|-----|----|--------------------------------|
| Yes | No | Numbness or tingling in extremities? | Yes | No | Confusion-spells/ Memory loss? |
| Yes | No | Extremity weakness? | Yes | No | Seizures |
| Yes | No | Burning or stinging pain in extremities? | Yes | No | Paralysis? |
| Yes | No | Imbalance when walking? | Yes | No | Incoordination of arms? |
| Yes | No | Neck or Low back pain? | Yes | No | Slurred speech? |
| Yes | No | Involuntary movements? | Yes | No | Tremors? |

Signature: _____ Date: _____

NEUROLOGY OF ARKANSAS, PA

Julia M. McCoy, M.D.

If you answer yes to any of the following questions, you must contact our office immediately to ensure proper care.

1. Have you had a Nerve Conduction study done in the last 6-12 months? Y N
If so, when and by whom? _____
Please supply our office with a copy of the results.
2. Is your condition related to a Motor Vehicle Accident? Y N
3. Do you have an attorney handling a personal injury case for you? Y N
4. Is this Work Comp? Y N

I have answered the above questions to the best of my knowledge. I understand I am to contact Neurology of Arkansas @ 501-993-3715 if I have answered yes to any of the above questions.

Signature: _____ Date: _____

[Neurology of Arkansas, PA]
NOTICE OF PRIVACY PRACTICES
Effective Date: October 1, 2013

This Notice was most recently revised on March 1, 2020.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Jocelyn Schuermann

Mailing Address: P.O. Box 16563, Little Rock, AR 72231-6563

Telephone: 501-993-5715

Fax: 866-816-9411

E-mail: jmm@neurologyofarkansas.com

About This Notice: We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)? Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI: We may use and disclose your PHI in the following circumstances: **For Treatment.** We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians. **For Payment.** We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies. **For Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes. **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. **Minors.** We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. **Personal Representative.** If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI. **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law. **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat. **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI. **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation. **Military and Veterans.** If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military. **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness. **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure. **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us. **Law Enforcement.** We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime. **National Security.** We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President. **Coroners, Medical Examiners, and Funeral Directors.** We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so. **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures: Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information: Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI: You have the following rights, subject to certain limitations, regarding your PHI: **Right to Inspect and Copy.** You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review. **Right to an Electronic Copy of Electronic Medical Records.** If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI. **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e mail), of any breach of your Unsecured PHI. **Right to Request Amendments.** If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement. **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment. **Right to Restrict Certain Disclosures to Your Health Plan.** You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service. **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website: <http://www.neurologyofarkansas.com>

How to Exercise Your Rights: To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice: The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

Optional Provisions to be Included as applicable:

Foreign Language Version. [Note: Foreign language versions are not required by HIPAA, but federal law requires a provider to make material distributed to the public, such as a Notice of Privacy Practices, available in the languages of persons with limited English proficiency in the provider's service area.]

Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

Newsletters and Other Communications. We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating. [Note: Use only if the practice intends to send newsletters or similar communications to patients.]

Fundraising Activities. [Note: Use only if the practice intends to engage in fundraising.]

Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law. [Note: Use only if the practice records or maintains psychotherapy notes.]

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. [Note: Use only if the practice participates in research activities.]