Patient Registration Form – EMG

Patient Name:	Preferred:	
Address, City, State, Zip:		
DOB:	Social Security #:	
Email Address:		
Home Phone:	Appointment Reminder Method	
Cell Phone:	☐ Home Phone ☐ Cell Phone/Text	
Work Phone:	☐ Work Phone ☐ Email	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's Name:	
Financial Responsibility: ☐ Self ☐ Other, Please List	Parent/Legal Guardian Name:	
Address and Phone Number, if Different from Above:		
Social Security #:	DOB:	Relation:
2nd Contact Info and Phone:		Relation:
General Physician:	Referred By:	

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at HPRC Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to HPRC Physical Therapy. I authorize the filing of claims to my insurance plan and authorize HPRC Physical Therapy to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name and Relationship to the Patient

Patient name:	DOB:

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize HPRC Physical Therapy and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting HPRC Physical Therapy or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify HPRC Physical Therapy immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders from HPRC Physical Therapy at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here. https://hprc.net/wp-content/uploads/sites/20/2026/01/HPRC-Website-Privacy-Policy-Terms-11-2025.pdf

☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized HPRC Physical Therapy to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

Patient name:	**DOB:**

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of HPRC Physical Therapy to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of $50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Printed name Relationship to patient

INFORMED CONSENT FOR ELECTROPHYSIOLOGIC TESTING

Patient Name: _____ **DOB:** _____

PURPOSE OF INFORMED CONSENT

The purpose of this Informed Consent is to describe electrophysiologic testing that was deemed appropriate by your physician for the purpose of diagnosis of your condition, as well as to inform you of the possible benefits and risks of undergoing such testing, to inform you of alternatives to such testing and risks of not undergoing such testing. Your participation in the prescribed electrophysiologic testing is strictly voluntary.

DESCRIPTION OF TESTING

Electrophysiologic testing that your physician has prescribed consists of obtaining a directed history of health and medical problems, a neurological examination, a Nerve Conduction Study (NCS), and Electromyography (EMG). All these components are referred to in this Informed Consent as "Electrophysiologic Testing".

Nerve Conduction Studies

Nerves conduct electrical signals generated in certain areas of the brain. These signals are carried through nerves to muscles. Upon receiving these signals, or stimuli, muscles contract and perform movements. If muscles do not respond to such stimuli correctly, it is possible that corresponding nerves are not functioning properly. A Nerve Conduction Study is performed to establish whether nerves carry (or conduct) stimuli normally. To perform a Nerve Conduction Study, surface electrodes are taped over several zones on the skin and muscles. The nerves which supply those zones or muscles are then stimulated with a surface probe and the resulting electrical responses are recorded by the surface electrodes, which are in turn attached to an EMG machine. The electrical responses provide detailed information about nerve function. These stimuli feel like a small shock (as a pinch or tingling) and are almost always well tolerated. One or more nerves may be tested during this procedure.

Electromyography

If muscles do not respond correctly to stimuli produced in the brain and conducted to these muscles by corresponding nerves, it is possible that the muscle does not process these stimuli normally, even though the nerves are intact. To establish whether this is true, electromyography is performed. During this test, a very small disposable needle electrode (smaller than the needle employed during a blood draw) is placed in one or more muscles. The electrical activity of the muscle is fed back through the electrode to the EMG machine when the muscle is at rest and then when it is voluntarily activated by the patient. The information obtained from EMG provides insight into muscle function.

Test Results

At the end of the study, the results of the neurologic examination, the NCS and EMG are combined to help your physician diagnose problems with nerves and muscles and connections between them (neuron-muscular junctions), as well as areas in the brain that control these nerves and muscles.

POSSIBLE BENEFITS OF ELECTROPHYSIOLOGIC TESTING

Electrophysiologic medicine is the study of diseases of nerves and muscles. Your doctor has recommended an EMG test to see if your muscles and nerves are working right. The results of the tests will help localize the problem and establish its severity.

Benefits of electrophysiologic testing may be decreased by factors that interfere with the testing and affect its accuracy. These factors include medications such as muscle relaxants and anticholinergics, presence of excess fatty tissue between the muscle and skin, application to the skin of medicinal and/or cosmetic lotions or creams, patient's ability to cooperate with the physician during testing, or patient's failure to follow physician's instructions, as well as patient's age (nerve conduction can vary with age and normally decreases as a person grows older).

POSSIBLE RISKS OF ELECTROPHYSIOLOGIC TESTING

Electrophysiologic testing involves insertion of disposable needle electrodes into skin and muscles and electrical stimulation of muscles (EMG). As such, they may cause discomfort and pain during the test. Since every patient tolerates discomfort and pain differently, it is impossible to predict how discomforting and/or painful this test will be for you. Most patients describe the discomfort as mild.

Minimal bleeding may occur during or after the test at the site of insertion of needle electrodes. A small bruise or bump may develop under the skin where the needle was inserted. Therefore, it is very important for you to disclose to your physician whether or not you have a bleeding problem, or whether or not you have been taking blood-thinning medication, such as Coumadin or Heparin.

Patient name:	DOB:

Electrophysiologic Testing may interfere with the electrical devices implanted in the body. Therefore, it is very important for you to disclose to your physician if you have such a device implanted in your body (for example, a pacemaker in the heart, defibrillator, cochlear implant, or spinal cord simulator).

Even though sterile, disposable electrodes are used for Electrophysiologic Testing, the site of insertion of needle electrodes may become infected, although the risk is minimal. This risk elevates, however, if normal hygiene is not maintained after the completion of the test. After the test, the muscle (or several muscles) may feel tender and bruised for a few days.
Overall, Electrophysiologic Testing is safe, and electric stimulation is too weak and short to cause an injury or permanent damage.

By signing this Informed Consent below, you affirm that you have read and understood possible risks that may result from Electrophysiologic Testing and have voluntarily assumed these risks for the benefit of undergoing Electrophysiologic Testing. You agree not to hold HPRC Physical Therapy, its directors, officers, shareholders, business associates, and other employees liable for any occurrence of such risks.

INFORMED CONSENT TO UNDERGO ELECTROPHYSIOLOGIC TESTING

By signing this Informed Consent I acknowledge the following:

- I have received a copy of this Informed Consent form and have carefully read and considered its contents.
- I have had an opportunity to ask questions about the procedures, potential benefits and risks, and additional considerations associated with Electrophysiologic Testing (or a patient, who is a minor).
- All my questions have been answered to my satisfaction, and I have had adequate time to reach my voluntary and informed decision to consent to undergoing Electrophysiologic Testing to which I attest by signing this Informed Consent below.

_____ _____

Patient/Guardian signature Date

_____

Print name and relationship to patient

This form only needs to be completed by patients with Medicare coverage.

MEDICARE SECONDARY PAYER (MSP) FORM		
Patient Name:	**DOB:**	
Part I		
1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: **Attorney's Name**: _____ **Address**: _____ **Phone Number**: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No
Part II		
1. Are you entitled to Medicare based on? *Check the box that applies* ☐ Age (65 & older) – go to question #2 ☐ Disability – go to question #2 ☐ End Stage – Go to **Part III**		
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage: ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u> ☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
Part III		
Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.		
1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ No
If yes to BOTH questions, GHP is primary during the 30-month coordination period		
Please provide a copy of your group health insurance if determined to be primary.		
Signature of Patient/Representative: Date:		
Relationship to Patient:		