Anoop K. Reddy MD
4446 E. Fletcher Ave. Suite E, Tampa, FL 33613 **(813) 558-8878**

Description

Electromyography (EMG)

- (ee-LEK-troh-my-AH-gruh-fee) a test used to detect nerve function. It measures the electrical activity generated by muscles.
- During this test, a small needle is inserted into a muscle to record the level of activity. You may feel as though your skin is being pinched.
- Evaluates nerve and muscle function and identifies nerve damage.
- Records the electrical responses of muscles while at rest and during voluntary action, contraction, and electrical stimulation.
- Plot of the electrical activity produced, recorded by a fine needle inserted in the muscle.
- It is used to determine the origin of muscular problems.
- It can be used to test whether nerve impulses to the muscle are working normally and whether the muscle is responding as it should.

Nerve Conduction Velocity/Study (NCV)

- A nerve test which utilizes mild and gentle electrical stimulation to the nerve to determine the medical condition of that nerve, similar to a battery pulse.
- Small metal electrodes will be placed on your skin and the physician will apply mild electrical currents to your skin. Your muscles will twitch but the test will not harm you.

Important – Patient Instructions

For your safety and for the success of your test, please hold blood thinners (anticoagulants) such as Coumadin (warfarin), Pradaxa, Xarelto, or Eliquis for three days prior to exam if permitted by your prescribing physician. Aspirin is permitted without change.

Upper Extremities - EMG/NCV

- No creams/lotions/oils on hands/arms
- Bring or wear a tank top or sleeveless shirt
- Bring winter gloves (or a pair of socks to use as gloves)
- No jewelry **(rings or bracelets)**

Lower Extremities - EMG/NCV

- No creams/lotions/oils on legs/feet
- Wear modest underwear
- Bring or wear heavy socks
- No jewelry **(ankle bracelets)**

Other Information

- Dr. Reddy will review the results and dictate a report with the findings which will be forwarded to the ordering physician. These results, combined with your medical history, symptoms, physical and neurological exams and other tests will assist **your** physician in developing a diagnosis and treatment plan. Please contact your ordering physician to obtain results so they can review them with you.
- Please arrive 10 minutes prior to your scheduled appointment. If you arrive more than 15 minutes late, you will be rescheduled. **If you fail to show, arrive excessively late or cancel your appointment within 48 hours, a $50 fee will be assessed to your account. In order to reschedule, you must satisfy this balance.**
- Children are not permitted in the exam room and may not be left attended in the waiting area.

Anoop K. Reddy, M.D., P.A.

Name:_____ Date of Birth:_____ Date:_____

EMG/NCV QUESTIONNAIRE

Who is your referring doctor? _____

What is the reason you are having the test? _____

_____

Are you currently taking any blood thinners such as **Coumadin (warfarin), Pradaxa, Xarelto, or Eliquis**? □ Yes □ No Date of last dose_____

Do you have any history of bleeding problems?(i.e. Hemophilia). □Yes □ No

Do you have any **personal** (not family) history of diabetes? □ Yes □ No

Do you have any history of alcohol abuse? □ Yes □ No

Anoop K. Reddy, MD

NEW PATIENT INFORMATION

PERSONAL INFORMATION

NAME: _____ DATE: __/__/____

DATE OF BIRTH: ____/_____/_____ AGE: _____

SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY: _____

CURRENT ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (_____) _____ CELL #: (_____) _____

IS THE ABOVE YOUR PERMANENT/MAILING ADDRESS? ☐ YES ☐ NO
IF NO, PLEASE LIST YOUR PERMANENT/MAILING ADDRESS: _____

EMAIL ADDRESS _____

DO YOU HAVE A LIVING WILL? ☐ YES ☐NO

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ LIFE-PARTNER

RACE: ☐ **WHITE** ☐ **BLACK/AFRICAN AMERICAN** ☐ **HISPANIC** ☐ **ASIAN** ☐ **OTHER** ☐ **I DO NOT WISH TO PROVIDE**
ETHNICITY: ☐ **HISPANIC OR LATIN** ☐ **NON-HISPANIC** ☐ **I DO NOT WISH TO PROVIDE**
PRIMARY LANGUAGE: ☐ **ENGLISH** ☐ **SPANISH** ☐ **INDIAN** ☐ **RUSSIAN** ☐ **OTHER**

PHARMACY NAME: _____ PHONE: _____
LOCATION: _____

EMPLOYER: _____ OCCUPATION: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

HOME # (_____) _____ ALTERNATE #: (_____) _____

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT OTHER THAN SPOUSE?

NAME: _____ RELATIONSHIP_____
PHONE # (_____) _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

OFFICE FINANCIAL POLICY

Our goal is to deliver the highest quality medical care as efficiently and effectively as possible. To maintain this standard of medical care, we must operate an efficient office from a business perspective. The following information will provide you with some of the financial guidelines of our office:

OFFICE CHARGES: Unless you are a patient with Medicare, an HMO, or PPO, payment is due at the time of service and may be made by cash, check, Visa, or MasterCard. Timely payments help us hold down the high cost of health care. An itemized statement will be given to you that you may attach to your insurance company's claim form for your reimbursement. Checks returned **for any reason**, will be assessed a $25.00 non refundable service charge. Past due accounts will be assessed any collection costs which may include attorney in addition to the balance owed.

If you are a member of an HMO or PPO, you will be required to make your necessary co-payment at the time of your visit. **It is your responsibility to arrange with your primary care physician to bring your referral with you for visits and diagnostic testing**. We are required by our HMO/PPO contracts to **reschedule any non-emergency appointment** until the proper authorization is granted.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at A.K. Reddy, M.D. P.A. and you have not obtained such authorization or referral;(ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at A.K. Reddy, M.D. P.A. are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at A.K. Reddy, M.D. P.A.; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

If you have **MEDICARE**, we accept assignment for Medicare claims. If you have a supplemental policy, that directly crosses over from Medicare, we will file this for you as well. If you do not have one of these supplemental insurances, or have not met your yearly Medicare deductible, we ask that you pay your co-payment amount at the time of service.

APPOINTMENTS NOT CANCELLED WITHIN 48 BUSINESS HOUR ADVANCED NOTICE ARE SUBJECT TO CHARGES TO THE PATIENT'S PERSONAL ACCOUNT. (PLEASE SEE CANCELLATION POLICY)

Should you have any questions regarding our policies or a special circumstance that you would like to discuss we invite you to speak with our office staff prior to your visit.

INSURANCE INFORMATION

PLEASE PROVIDE ALL INSURANCE CARDS TO FRONT OFFICE STAFF SO THAT PHOTO COPIES CAN BE MADE!

ONLY FILL OUT THE FOLLOWING IF YOU ARE **NOT** THE PRIMARY SUBSCRIBER TO THE INSURANCE:

PRIMARY INSURANCE: _____

SUBCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

SUPPLEMENTAL INSURANCE: _____

SUBCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

AUTHORIZATION

I authorize the release of any medical information acquired in the course of my examination or treatment to process an insurance claim and that I have read and understand the office financial policy. I certify that all of the information given is true and correct to the best of my knowledge. I also request that payment of authorized services be made on my behalf to the physician rendering services for any balance not paid directly by myself. I authorize you to give me reasonable and proper medical care by today's standards of care. I have read and/or received a copy of the practice's notice of privacy practices.

Medicare patients: I certify that the information given to me in the applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

SIGNATURE: _____ DATE: _____

Note: be sure to provide ALL insurance cards and a photo I.D. to front office staff so a copy can be made and placed in your record.

Anoop K. Reddy, M.D., P.A.

Diplomate of the American Board of Psychiatry and Neurology

4446 E Fletcher Avenue, Suite E, Tampa, FL 33613

Phone: (813) 558-8878

Cancellation Policy

Appointments are commitments between the patient and doctor to share a given time. Appointments that are not kept waste not only the doctor's time, but office staff and leave those patients with urgent healthcare needs waiting.

We are willing to work with our patients who are willing to work with us. We understand that there are some circumstances that cannot be avoided. If you have to cancel/reschedule your appointment it is appreciated if it is done as soon a possible. **Patients who do not cancel within 48 business hours prior to the scheduled time will be automatically billed for the visit that is missed**. _____(initial) This will be charged to the personal patient account and is not covered by insurance.

By signing this form you agree that you have been notified and understand the cancellation policy of the practice.

Patients Name: _____

Signature: _____

Date signed: ____/____/_____

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4446 E. Fletcher Ave. Ste E.Tampa, FL 33613
Ph: (813) 558-8878 Fax: (813) 558-0259

Authorization for Release of information

I hereby give my permission to Anoop K. Reddy, M.D. PA to request any medical records required for treatment from my primary care physician, referring physician, or any other physician involved in my treatment.

PATIENT INFORMATION:

_____
Full Name

_____
Date of Birth

_____
Signature of Patient or Authorized Representative*

Date of signature: _____

Relationship to patient: _____

*If legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization.

Please fax records to number listed above, unless otherwise specified.

This authorization will expire automatically one year after the date signed. You may revoke this authorization at any time by notifying the office of Anoop K. Reddy, MD in writing to the address above. The written revocation will not affect any information already disclosed to the office of Anoop K. Reddy, MD prior to revocation.