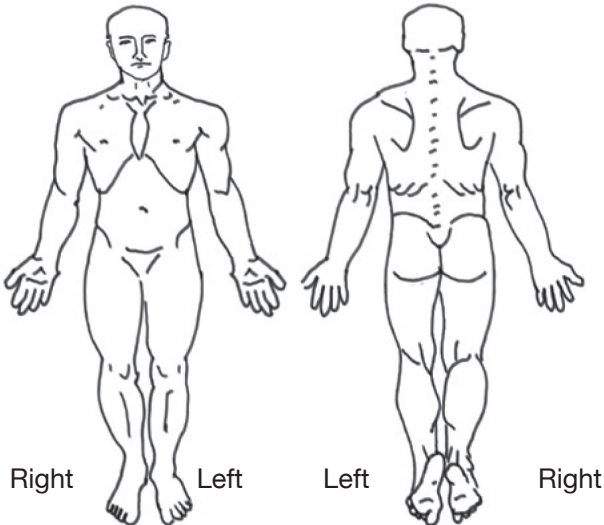


800.224.1807

DATE																																												
LAST NAME		FIRST		MIDDLE																																								
PHYSICAL ADDRESS		APT. #	CITY	STATE																																								
MAILING ADDRESS (PO BOX) <input type="checkbox"/> Check if same as above		CITY	STATE	ZIP																																								
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE	BIRTHDATE		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED																																								
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WHAT ARE YOUR SYMPTOMS:																																												
ARE YOUR SYMPTOMS RELATED TO: <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> A motor vehicle accident <input type="checkbox"/> Other _____																																												
<p>CHECK THE BOXES THAT APPLY:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Joint pain</td> <td><input type="checkbox"/> Numbness</td> <td><input type="checkbox"/> Burning</td> <td><input type="checkbox"/> Shingles</td> <td><input type="checkbox"/> Easy bleeding/bruising</td> </tr> <tr> <td><input type="checkbox"/> Muscle pain</td> <td><input type="checkbox"/> Tingling</td> <td><input type="checkbox"/> Weakness</td> <td><input type="checkbox"/> Blood Thinners</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Thyroid Disease</td> <td><input type="checkbox"/> Defibrillator</td> <td><input type="checkbox"/> Liver Disease</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Pacemaker</td> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> Stroke</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Artery Disease</td> <td><input type="checkbox"/> Neuropathy</td> <td><input type="checkbox"/> Chemotherapy/Radiation</td> <td colspan="2"><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Carpal tunnel surgery</td> <td><input type="checkbox"/> Neck surgery</td> <td><input type="checkbox"/> Knee surgery</td> <td colspan="2"><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Cubital tunnel surgery</td> <td><input type="checkbox"/> Low back surgery</td> <td><input type="checkbox"/> Ankle surgery</td> <td colspan="2"></td> </tr> <tr> <td><input type="checkbox"/> Shoulder surgery</td> <td><input type="checkbox"/> Hip surgery</td> <td><input type="checkbox"/> Foot surgery</td> <td colspan="2"></td> </tr> </table>					<input type="checkbox"/> Joint pain	<input type="checkbox"/> Numbness	<input type="checkbox"/> Burning	<input type="checkbox"/> Shingles	<input type="checkbox"/> Easy bleeding/bruising	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Tingling	<input type="checkbox"/> Weakness	<input type="checkbox"/> Blood Thinners		<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Cancer	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke		<input type="checkbox"/> Artery Disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Other _____		<input type="checkbox"/> Carpal tunnel surgery	<input type="checkbox"/> Neck surgery	<input type="checkbox"/> Knee surgery	<input type="checkbox"/> None		<input type="checkbox"/> Cubital tunnel surgery	<input type="checkbox"/> Low back surgery	<input type="checkbox"/> Ankle surgery			<input type="checkbox"/> Shoulder surgery	<input type="checkbox"/> Hip surgery	<input type="checkbox"/> Foot surgery		
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<input type="checkbox"/> Shoulder surgery	<input type="checkbox"/> Hip surgery	<input type="checkbox"/> Foot surgery																																										
<p>FAMILY HISTORY</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Nerve disease (CMT) <input type="checkbox"/> Muscle disease <input type="checkbox"/> None																																												
<p>HAVE YOU EVER HAD AN EMG/NCS BEFORE? <input type="checkbox"/> yes <input type="checkbox"/> no</p>																																												
REFERRED BY			DATE OF RETURN VISIT																																									
SPOUSE (or responsible party) NAME			SPOUSE'S BIRTHDAY																																									
SPOUSE'S SOCIAL SECURITY NO. (TRICARE ONLY)																																												
IN CASE OF EMERGENCY NOTIFY & PHONE IF DIFFERENT THAN SPOUSE.																																												

PLEASE SHADE WHERE YOU ARE HAVING SYMPTOMS



Insurance Authorization and Assignment

I request that payment of authorized Medicare, Medigap, Commercial Carrier, or Workers Compensation benefits on my behalf, be made to Bingham Nerve & Muscle for any services provided to me by Bingham Nerve & Muscle. I authorize Bingham Nerve & Muscle to release to the Health Care Administration and its agents any information needed to determine benefits payable for related services. I understand that I am responsible for any deductible, co-pay, or services not covered by my insurance carrier. I also authorize the physician to release any information required by my insurance company and/or another physician. I give authorization and consent for treatment to Bingham Nerve & Muscle.

X _____
Patient Signature or Legal Guardian (if a minor)

Date

CONSENT FOR MEDICAL TREATMENT

I authorize Bingham Nerve & Muscle physicians and personnel to render medical treatment and evaluation needed. I further authorize order of other diagnostic tests and treatment that may be necessary.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I have been informed, and given the opportunity to review and secure a copy of the Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment, payment or health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of Bingham Nerve & Muscle.

I agree that Bingham Nerve & Muscle may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

CONSENT FOR FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by Bingham Nerve & Muscle. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of my charges. I assign benefits to and authorize direct payment to Bingham Nerve & Muscle of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for all charges not paid pursuant to this agreement.

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

JACKSON
3035 N. Highland Ave.

SOUTHAVEN (MISSISSIPPI)
391 Southcrest Circle, Suite 104

DYERSBURG
640 Highway 51 Bypass E., Suite D

GREENWOOD (MISSISSIPPI)
1604 Leflore Ave.

GERMANTOWN
1365 S Germantown Rd.

TUPELO (MISSISSIPPI)
634 Spicer Dr., Suite A

UNION CITY
1720 E. Reelfoot Ave., Suite 201

DICKSON
421 Henslee Dr.

PARIS
430 S. Lake St.

SELMER (NEW ADDRESS!)
832 Mulberry Ave.