UNITED DIAGNOSTICS

SLEEP STUDIES • VEEG • DME

PATIENT REGISTRATION FORM

Today's Date:	Referring Physician:	
PATIENT INFORMATION		
Last Name:	First:	MI:
Is this guarantor a legal representative? Yes ☐ No ☐ Social Security No:	Marital Status (circle one):	Single / Mar / Div / Sep / Wid
Date of Birth:	Age:	Sex: M ☐ F ☐
Street Address: P.O. box:		Employment Status (circle one): Employed Unemployed Retired Full-Time Student Part-Time Student
Home Phone No.:	Cell Phone No.:	
Employer/College:		
Employer Address:	Work Phone No.:	Ext.:
City:	State:	ZIP Code:

PRIMARY INSURANCE INFORMATION			
Person Responsible for Account:			
Relationship to the Insured:	Date of Birth:		
Company:	Co-Payment Amount:	Deductible:	
Group Number:	Policy Number:		
Address (if different from patient):		Home Phone No.:	
City: State: ZIP Code:		Cell Phone No.:	
Employer of Person Responsible:		Work Phone No.:	
Employer Address:	City:	State:	ZIP Code:

SECONDARY INSURANCE INFORMATION			
Person Responsible for Account:			
Relationship to the Insured:	Date of Birth:		
Company:	Co-Payment Amount:	Deductible:	
Group Number:	Policy Number:		
Address (if different from patient):		Home Phone No.:	
City: State: ZIP Code:		Cell Phone No.:	
Employer of Person Responsible:		Work Phone No.:	
Employer Address:	City:	State:	ZIP Code:

IN CASE OF EMERGENCY	
Name of Local Friend or Relative:	Relationship to Patient:
Home Phone No.:	Cell Phone No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	Date:

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MEDICAL HISTORY QUESTIONNAIRE

Date:_____

Patient Name:_____

Date of Birth :_____

Reason Physician Requested VEEG Visit:_____

_____

Description of Symptoms and/ or Events: _____

_____

_____

_____

Past Medical History/ Mood Disorders:_____

_____

_____

Current Medications Including All Seizure Medication with Frequency and Dosage:

_____

_____

_____

Frequency of events: _____

Approximate Date of **First** Event:_____

Family History of Seizures or Mood Disorders:_____

_____

_____

Perinatal History:_____

Do you have nocturnal episodes?:_____

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BILLING PRACTICES

PLEASE READ THIS LETTER IN ITS ENTIRETY. IT CONTAINS IMPORTANT INSURANCE INFORMATION.

Dear Patient:

You are receiving this letter because you have chosen to participate in an Ambulatory Video EEG test administered by United Neuro Diagnostics, Inc. We have billed your insurance carrier for the services rendered.

We participate with multiple insurances and for the ones we are non-participating with, you, as the insurer, may have all correspondence and/or payments sent directly to you. It is imperative that upon receipt of such items you forward them directly to our office.

The insurance check should be endorsed by the policy holder and directly underneath the signature should be written, “Pay to the order of United Sleep Diagnostics, Inc.”. This will prevent the check from being cashed by anyone else. To avoid any billing errors, please also include any explanation of payment you receive to our office as well.

Included in the envelope addressed to the billing office should be the following:
Endorsed check and copy of Explanation of Benefits and Statement.

If you choose to cash the insurance check **(not recommended)**, you may send a personal check for the amount due. **NOTE:** There will be a fee for bounced checks.

As a reminder, if this bill is not paid in a timely manner and we are forced to institute collection efforts, you will be responsible for any reasonable costs incurred in that effort including, but not limited to: collection fees, attorney’s fees, and court costs. Should you have any further questions or concerns, please contact this office.

Thank you for your prompt attention in this matter.

Sincerely,
United Sleep Diagnostics

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CONSENT FOR VIDEO EEG TESTING

I _____ consent to medical testing for me or for the patient whom I am either the parent or authorized legal representative. All diagnostic testing has been explained to me and I understand the reason for this procedure.

CONSENT FOR VIDEO MONITORING

I _____ understand that it is necessary to have a video recording of my EEG testing in order to properly identify the relationship between my seizure activity and brain functioning. I understand that the video is used only for medical purposes and for my safety.

CONSENT FOR MEDICAL RECORDS RELEASE

I _____ (the patient or authorized legal representative of the patient) consent to release of medical information to my referring physician and any parties listed:

Physician Name & Contact Information: _____

_____

_____

Patient Signature: _____

Signature of Legal Representative: _____

Relationship of Legal Representative to Patient: _____

Date: _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT

Private and Group Accident and Health Insurance

I hereby direct and instruct _____ Insurance Company to pay by check made out and mailed to:

United Neuro Diagnostics, Inc.
50 Rose Place
Garden City Park, NY 11040

If my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

United Neuro Diagnostics, Inc.
C/O: 50 Rose Place
Garden City Park, NY 11040

For the professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Should the provider not participate with my insurance company, I understand that I will receive payment for the services rendered directly. I agree to send payment along with any correspondence and/or explanation of payment to the provider. Should I fail to forward payment to the provider and it becomes necessary for my account to be placed for collection, I also understand and agree that I will be responsible for any reasonable cost incurred in the collection process to include but not limited to: attorney fees, collection fees, etc.

I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I also authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, or Attorney in this case.

Date: _____

_____
Signature of Policyholder:

_____
Signature of Claimant (If Other Than Policyholder)

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PRIMARY INSURANCE

Insurance Company: _____ Member's ID #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to United Neuro Diagnostics, Inc. all benefits, if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. My signature below authorizes submission of this claim by provider, as well as any and all medical appeals on my behalf.

The above-named Company may use my health care information and may disclose such information to the above-named Insurance Company/Companies and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will be in force for one year from the date signed below.

Date: _____

_____

Please Print Name of Patient, Parent, Guardian or Personal Representative

_____

Signature of Patient, Parent, Guardian or Personal Representative

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ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Signature Date

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Skull Defect Worksheet

Setup Date: _____ Study Length: _____

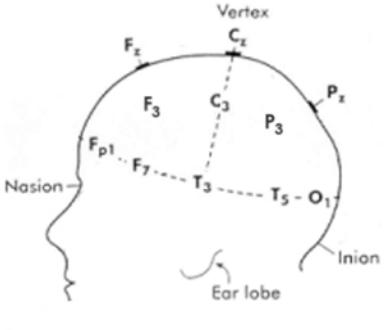
Patient Name:_____

DOB: _____ Sex: _____ Handedness: _____

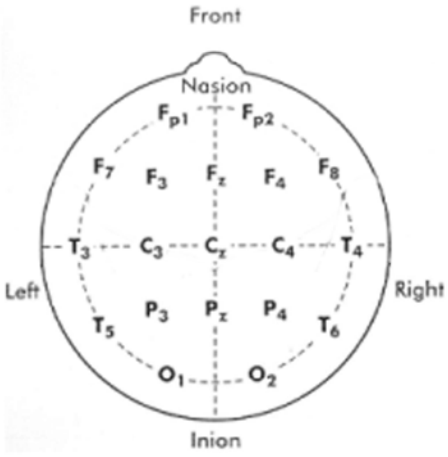
Date of Last Seizure: _____

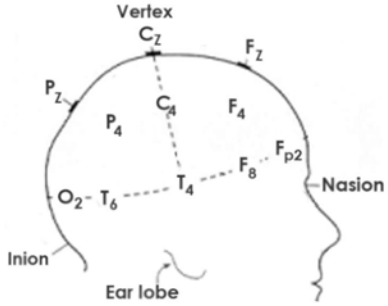
Technician Findings: _____

Circle Skull Defect Location:



Left Side





Right Side

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PATIENT SKIN ALLERGY QUESTIONNAIRE

Are you allergic to anything? Yes____ No____
If yes, please list:
_____
_____
_____

1) Do you have skin sensitivity to any of the following:
   - Soap Yes____ No____
   - Shampoo Yes____ No____
   - Laundry Detergent Yes____ No____
   - Perfume Yes____ No____
   - Body/Moisturizing Lotion Yes____ No____
   - Hand Cream Yes____ No____
   - Make-Up Yes____ No____
   - Eggs Yes____ No____

If you checked yes to any of the above, please describe the skin reaction:
_____
_____

2) Do you sunburn easily? Yes____ No____
3) Do you have skin reaction to GOLD/SILVER? Yes____ No____
4) Do you have latex sensitivity? Yes____ No____
5) Do you have psoriasis? Yes____ No____
6) Do you have eczema? Yes____ No____
7) Have you had an acid peel? Yes____ No____
8) Have you had a microderm abrasion or facial Yes____ No____
9) Do you currently use Retin A or any other skin treatments? Yes____ No____

(TO BE FILLED OUT BY THE TECHNOLOGIST)

- Was a patch test performed? Yes____ No____
- What were the results? Reaction____ No Reaction_____

I understand and acknowledge that there could be skin breakdown due to the long-term VEEG monitoring. If I have any questions or concerns after my VEEG testing, I will contact United Diagnostics.

Patient Name: _____

Patient Signature: _____

Technologist Applying Electrodes: _____

ORIENTATION CHECKLIST

PATIENT:	**DATE:**
UNIT#	**SETUP TECH:**

PRIOR TO SETUP:

- **INTAKE FORMS:**
  - **Collected registration forms, ID, and Insurance card**
  - **Reviewed of Skin Safety Questionnaire and medical history**
  - **Completed Skull Defect Worksheet**

- **EQUIPMENT INSPECTION:**
  - **Tablet System and Apollo are sanitized and are CLEAN**
  - **Camera, component cables, and portable pack are undamaged and functional**
  - **External and Internal Apollo Batteries are CHARGED for the study duration**
  - **Tablet system has an ACTIVE CELLULAR CONNECTION or if permitted IS ON THE PATIENT'S HOME WIFI for the monitoring team**

REVIEW OF VEEG INSTRUCTIONS AND EXPECTATIONS:

- **PATIENT EDUCTATION:**
  - **Explained the importance of the video and monitoring**
  - **Minimize scratching and pulling at the headwrap and electrodes**
  - **DO NOT chew ice, gum, or eat hard candy**
  - **DO NOT shower or get ANY OF THE EEG EQUIPMENT WET**
  - **DO NOT USE DEVICES WHILE THEY ARE CHARGING**

- **PATIENT DIARY:**
  - **Reviewed cover page with 24HR ON CALL PHONE NUMBER and EQUIPMENT RETURN TIME**
  - **Explained the daily log sheet and documentation of activities/ episodes**
  - **Explained the purpose of the push button/ event column if applicable**

- **PURPOSE OF ON-CALL TEAM AND MONITORING:**
  - **HIGHLIGHTED THE IMPORTANCE OF CALLING THE ON CALL TEAM FOR: Extreme itchiness or discomfort, if the headwrap is falling off, issues with the equipment, or further clarification of study instructions given at setup**

PHYSICAL EEG EQUIPMENT:

- **BEFORE THE PATIENT LEAVES, THEY MUST UNDERSTAND:**
  - **HOW to plug in the LONG GRAY power cable for the VEEG monitoring system**
  - **WHERE is the power button on the monitoring system**
  - **WHY it is important get the monitoring system plugged into power ASAP after leaving**
  - **WHEN in doubt, to call the on-call team**

Patient Signature: _____

Date:_____

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VIDEO AMBULATORY EEG

PATIENT DIARY

Patient Name: _____

Patient ID: _____

Date of Birth: _____

Start Date: _____

Disconnect Date: _____

Return Time: _____

On-Call Phone Number: 516-734-0425

Please leave your name, phone number, unit number (located at the top of this page), and the nature of your call. We will return your call and/ or troubleshoot your issue remotely.

Great Neck	Commack	Shirley	New York City
560 Northern Blvd, Ste 208 Great Neck, NY 11021	6080 Jericho Tpke, LL Commack, NY 11725	1500 William Floyd Pkwy, Ste 301 Shirley, NY 11976	199 3rd Ave, LL New York, NY 10003
Brooklyn/Bay Ridge	**Brooklyn/Park Slope**	**Tarrytown**	**Bronx**
9101 4th Ave Brooklyn, NY 11209	808 8th Ave, LL Brooklyn, NY 11215	505 White Plains Rd, Ste 103 Tarrytown, NY 10591	4238 Bronx Blvd Bronx, NY 10466

For scheduling or post-study questions, please call: 516-873-6500

DAY 1 - Date:

Time (Specify am/pm)	Push Buttons	Daily Activities/Symptoms
	✓	*Patient instructed by tech to test push button*
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	

DAY 2 - Date:

Time (Specify am/pm)	Push Buttons	Daily Activities/Symptoms

DAY 3 - Date:

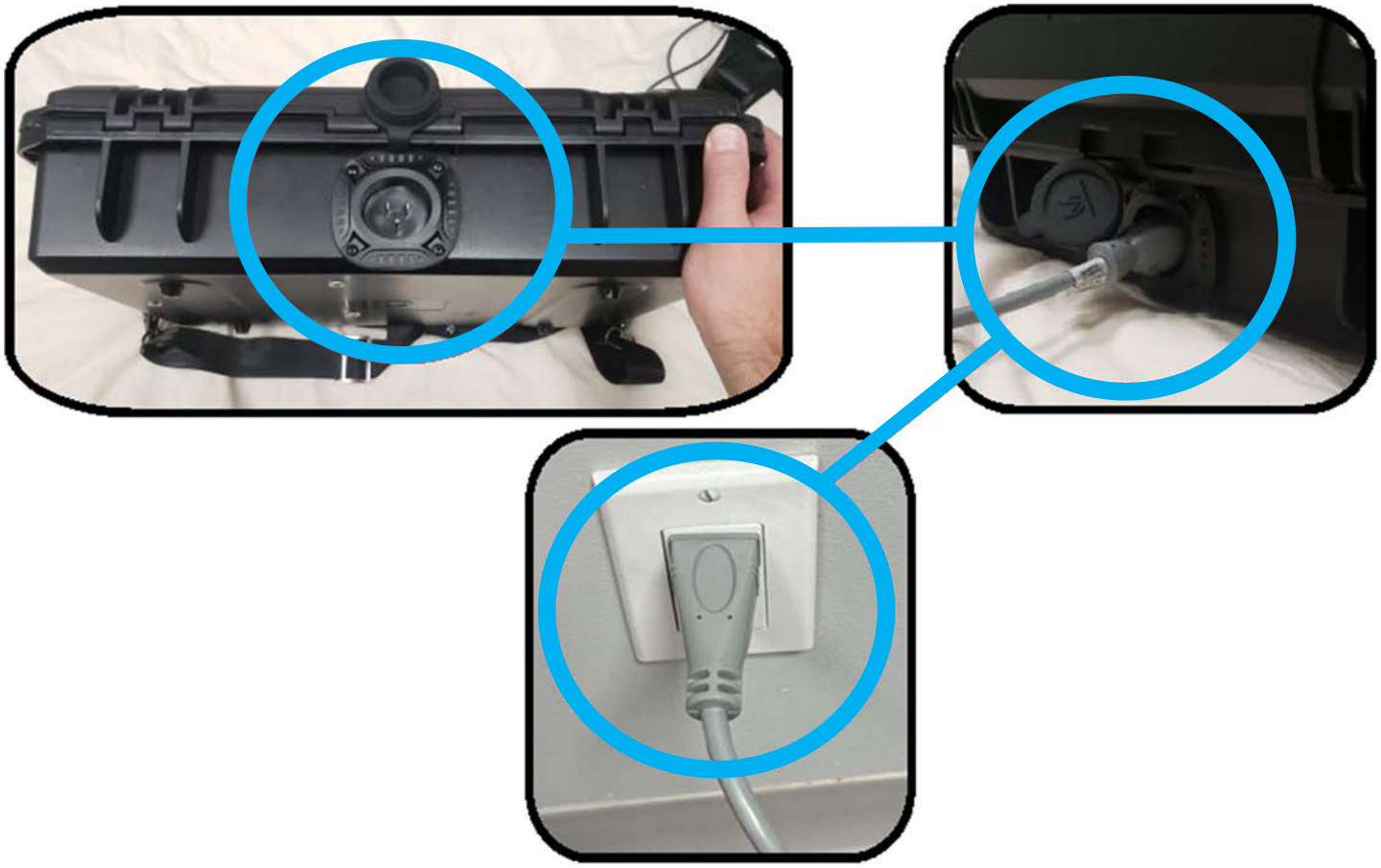
Time (Specify am/pm)	Push Buttons	Daily Activities/Symptoms

DAY 4 - Date:

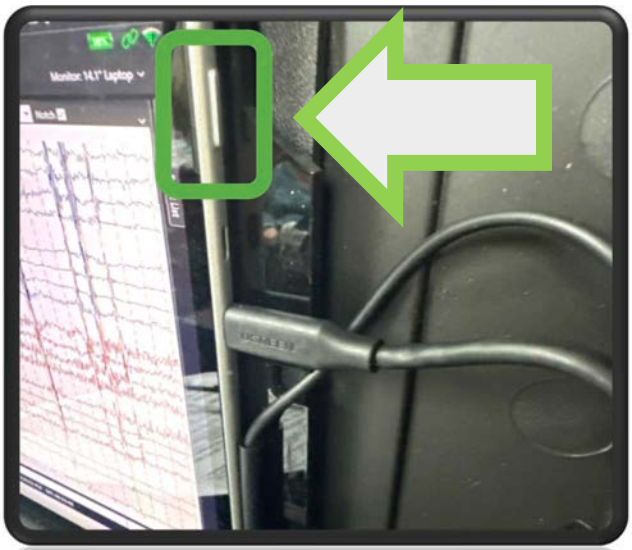
Time (Specify am/pm)	Push Buttons	Daily Activities/Symptoms

AT HOME INSTRUCTIONS & TROUBLESHOOTING

When home, open unit case and take the 10-foot, light gray power cable and attach it to the port located on the back of the unit case. Plug the power cable to a power source (outlet) in your home.

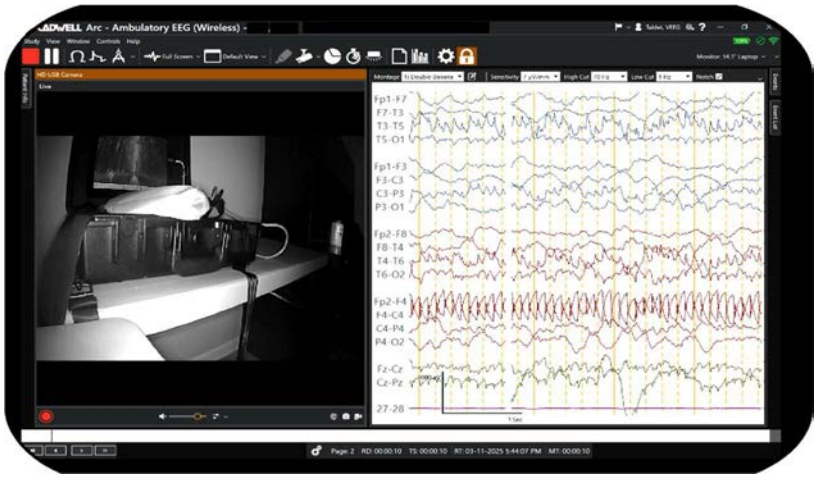


If your computer screen turns off, please press the power button located along the **RIGHT SIDE*** of the computer screen. Please note, your EEG (brain activity) is a constant recording and will continue to record even if the computer screen turns off. If you are unable to turn on your computer screen, please call the on-call line at **516-734-0425.**



***some models will have a cutout with the power button along the top edge of the tablet**

GENERAL INFORMATION



- Your computer screen should always look like the image to the left. On screen you will see the EEG tracings and a camera feed while the study is running.

• **Always keep the computer tablet/video camera unit plugged into the wall at all times, aside from move between rooms. Be sure to plug the computer unit back into the wall.**

• Do not close or cover the computer screen with any type of fabric to dim the brightness. The computer will overheat and turn off.

• When leaving the house, **DO NOT** take computer unit. Make sure it is plugged into the wall and recording prior to leaving.

• If you plug the computer unit into an outlet powered by a light switch, please keep the light switch on so the unit will continue to receive power.

• If an electrode or the head wrap has fallen off, call the on-call phone # **516-734-0425**

• The video camera will record in a light and/or dark room. The picture will adjust from color to black and white as needed.

• Make sure you are within view of the video camera as much as possible throughout your study, unless otherwise stated by your technologist.

• **CHILDREN MUST BE ATTENDED AT ALL TIMES BY PARENT OR CAREGIVER**

DO'S AND DON'TS

DO's

- You may use your cellphone, tablet, your computer, a microwave, play video games, and wear headphones during your study. Do not use electronic devices while they are charging or plugged into an outlet.
- You may reapply the EKG (chest electrodes) if one becomes loose. Use medical tape or a band-aid to help keep the EKG sticker in place.
- Keep your computer unit plugged into an outlet at all times.
- Wear a button up or zipper shirt so that when you change your clothes it doesn't interfere with the electrodes.
- You may leave the house during the study. Be sure to keep the unit plugged into the wall and the case open before leaving the house.
- Please call your on-call phone line at **516-734-0425** if you have any urgent issues or concerns.

DON'TS

- Do not take a bath, shower, or swim. You may take a sponge bath.
- Do not get any of the equipment or electrodes wet.
- Do not chew gum, ice, or hard candies consistently.
- Do not cover the computer screen with any type of fabric. It will overheat and turn off.
- Try not sweat excessively; **do not exercise, do not sit by the pool**
- Do not turn the video camera unit off or tamper with equipment. You run the risk of losing the entire study.
- Do not remove any wires or the headwrap.
- Do no drop or strike equipment.

PATIENT DIARY INSTRUCTIONS

DAILY ACTIVITIES TO LOG:

- Meals
- Bedtime and waking time
- Medications
- Brushing teeth
- Any other significant activities

Notate daily activities along with time and date on the diary log provided.
DO NOT** push the button to document daily activities. **ONLY** press for events or symptoms. See below.

"PUSH BUTTON EVENTS" TO LOG:

- At the onset of a seizure or an episode.
- Typical symptoms; i.e. loss of consciousness, tingling, staring, convulsions, jerking movements, stiffness, headaches, etc.

Notate and check box for push button events along with time and date on the diary log.

THE CADWELL EEG RECORDER

Inside your bag, you should see "Recording" and the battery percentage for your device on the screen.

Press any one of the **bottom four event buttons** on the Cadwell recorder. Push button can be pressed either before, after, or during an event.

DO NOT touch or unplug the cable between the box with the electrodes and the Cadwell Recording device.

If the cable becomes loose, the device will beep. If this happens, please contact the on-call phone line at

516-734-0425

UNITED
NEURO DIAGNOSTICS LLC
A VIDEO AMBULATORY EEG COMPANY

PATIENT INSTRUCTIONS FOLLOWING VEEG STUDIES

We hope that your test was as pleasant as possible and that your technologists made sure you were comfortable with all aspects of the testing process. Now that your test is over, please review the following information regarding further evaluation and treatment of your symptoms.

When you get home, please apply hair conditioner to your hair prior to washing. You do not need to wet your hair. Simply apply about a handful of conditioner to your hair and work it in. Let it sit for about 5-10 minutes. Using a large toothcomb, comb through your hair. After the 5-10 minutes, rinse out the conditioner using warm water. If there is any remaining paste, a repeat washing and rinse may be necessary.

Occasionally the skin cleanser, electrolyte paste, and electrodes cause minor skin irritations such as contact dermatitis. A red rash or small white pimples are the usual reaction. Wash the area with soap and cool water. You can treat the area with a first aid cream. You should seek medical attention if your rash does not improve after 3 days of self-care.

The data your study generates is approximately 100-300 files of data. This data is collected on the computer, but is analyzed and coordinated with your push button, video, and daily activity logs by the EEG technologist. All of this information is detailed into a report and sent to the interpreting physician within 48 hours. In some cases, the interpreting physician is not your physician.

The interpreting physician will review the clinical history, your logs, and all of the data. The interpreting physician will render a detailed report of the data. The physician will then dictate the final report, which will be sent to your physician.

Please make sure you have a follow-up appointment or call scheduled for approximately two weeks after your study with your physician. We recommend that you call your physician’s office the day prior to your appointment to verify that the final report is available.

We appreciate having the opportunity to provide you with quality diagnostic testing. Should you have any questions, please call us at **866-711-1299.**