Consent
for
Neuromonitoring Services

Consent to Diagnostic Testing: I authorize _____ (hereinafter called IONM Company) to provide me with the necessary Neurodiagnostic testing as requested by my physician(s). This consent and authorization includes Neurodiagnostic testing including but not limited to BAERs, NCV, SSEP, MEP, EMG, and EEG. I further understand that any questions I might have as to testing can be addressed to my physician(s) or the technical personnel.

Authorize to release Information: I authorize IONM Company to furnish requested information from the patient's medical and other records to (1) any insurance or third-party payer for the purpose of obtaining payment on the account; (2) any other person(s) or entities financially responsible for the patient's care or treatment and (3) representatives of local, state, or federal agencies in accordance with applicable law. I furthermore authorize IONM Company to release information from or copies of the patient's medical records to any referring physician or to any health care facility to which the patient may be transferred.

Authorization to Appeal and Assignment of Benefits: In consideration of medical services to be provided me, I hereby promise to pay for those services in accordance with the rates and terms now in effect at IONM Company to the extent that I am legally responsible for such payment. I hereby assign to IONM Company any and all benefits, interest, and rights (including causes of action and right to enforce payment) for services rendered under any insurance policy.

Assignment of Rights: I, _____, hereby assign to IONM Company to the extent allowed by law, the right to collect the unpaid insurance benefits, penalties, attorney's fees, court cost and all other recoverable damages of any nature from the medical insurance company that provided coverage on the date listed herein. Theses services provided are considered out-of-network. The assignment of the right to sue the undersigned's medical insurance company in the undersigned's/insured's name and assert all claims that the undersigned/insured will have against the insurance company resulting from, or in way pertaining to, the medical coverage that the undersigned is alleged to have had with his/her insurance company in regard to medical procedures performed on _____/_____/_____. Additionally, the undersigned agrees to cooperation with IONM Company in providing documents and testimony concerning the rights assigned herein.

Risks of Neurological Monitoring: I acknowledge that the following risks of neurological monitoring have been explained to me and I have had an opportunity to ask questions regarding this procedure. The risks are as follows: soreness/bruising/skin damage at the site of electrode and/or adhesive placement, burns from stimulating electrodes, seizures, tongue laceration, chipped teeth, redness/itching at the site of the gel electrodes, and nervous system injury.

The undersigned certifies that he/she has read and understands the foregoing, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____

Patient Signature Date

PATIENT STICKER

Case: _____ **Machine:** _____

Tech: _____ **Pre-op Time:** _____

Height:_____ **Weight:**_____

(1) Diabetes? Y N **if yes…IDDM?** Y N **How long?**_____

(2) Smoker? Y N **if yes…PPD**_____ **How long?**_____

(3) Seizure? Y N **if yes, details** _____

(4) Hypertensive? Y N **(5) Blood thinners?** Y N

(6) Stroke? Y N **(7) Aneurysm Clip?** Y N

(8) Defib/Pacemaker? Y N **(9) Spinal Stim?** Y N

(10) Skin Sensitivity? Y N **(11) Allergies?** Y N

(12) Hardware? Y N **(13) Skull Fx?** Y N

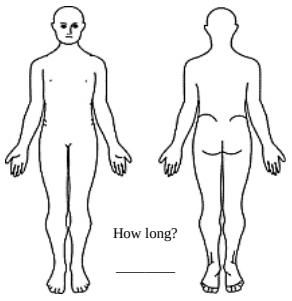
(14) Previous Sx? Y N **(15) Mastectomy?** Y N

Notes: _____

_____

Patient History

R L R



FOR IMAGE:

P - Pain T - Tingling
H - Hardware N - Numbness
W - Weakness S - Spasms

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