NEUROLOGY CENTER OF FAIRFAX, LTD.

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ELECTROMYOGRAPHY / NERVE CONDUCTION CONSENT

PRINT PATIENT NAME: _____ Date of Birth: _____

Electromyography (EMG) and Nerve Conduction Studies (NCS) are utilized to help evaluate disorders of the nerves and muscles.

I agree that if my insurance coverage is denied for any reason, I will be responsible for all costs. I agree to update my insurance information regularly and to notify the Neurology Center of Fairfax, Ltd. immediately of any insurance changes. I further agree to be responsible for the outstanding balance on this account and to pay all reasonable costs of collection including attorneys' fees at 40% of the outstanding balance and monthly interest at 1.5% should this account become overdue.

I have received a copy, read, and understand the risks and benefits of the scheduled Electromyography and Nerve Conduction Studies, which may include inserting a thin disposable needle into my muscle and applying mild shocks to my nerves. I understand bruising and discomfort at the site of needle insertion may occur.

Signed: _____ Date: _____