NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

Information for Testing Only Patients

Thank you for choosing the Neurology Center of Fairfax to provide your neurological testing. Our goal is to provide you with top quality care. Please help us by providing your most up to date medical information at the time of your testing.

Please read the following instructions before you come to the office for your testing.

Prior to your test please:

- Fill out all information forms. We need current information to provide you with the best care.
- You can download the forms from our website: www.neurologycenteroffairfax.com
- You must bring your testing order and all completed forms to your appointment or we will not be able to perform your testing.
- Your co-payment costs, co-insurance, and any deductibles are due at the time of service. If you do not pay these costs at the time of your visit, there is a $10 administrative fee and an additional $10 service charge for each bill we send. These charges are not covered by health insurance. We accept VISA, MasterCard, Discover, cash and checks.
- Please be respectful of other patients and arrive 15 minutes before your scheduled test time. Please call us if you are delayed by traffic at 703-876-0800. If you are late, we may not be able to see you the same day. We understand the problems with traffic in Northern Virginia, but we cannot inconvenience patients who do arrive on time for their appointments.
- Our office does not communicate with patients via email or text messaging as these are not HIPAA compliant. You may use our web portal for secure communications with our staff.

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Patient Authorizations

Patient Name: ____

Date of Birth: ____________________________

(Please read carefully. You are authorizing these actions.)

I hereby authorize the Neurology Center of Fairfax, Ltd. (NCF) to apply for benefits on my behalf for covered services rendered by NCF, to myself or to my dependent. Authorization is effective as of today. I request payment from my insurance carrier and/or Medicare Part B to be made directly to NCF.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including protected health information (PHI) for this or any other related claim, to my insurance carrier or in the case of Medicare Part B benefits to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS). I permit a copy of this authorization to be used in place of an original. It is possible that services provided to me by NCF may not be covered by Medicare or by my insurance. I agree to assume responsibility for full payment of all services if Medicare or other insurance payment is denied. I further agree to be responsible for the outstanding balance on this account and to pay all reasonable costs of collection including attorney's fees at 40% of the outstanding balance and monthly interest at 1.5%, should this account become overdue.

I understand that payment for all services is due and payable in full at the time of service, and that full payment for services may be required at the time of service. This includes, but is not limited to, my co-payment, co-insurance and deductibles. I agree to provide NCF with my current insurance card, government issued identification, and a valid referral (if required) at the time services are rendered. I understand that it is my responsibility to obtain required referrals.

I understand that although my insurance may pay part or all of the charges I incur, I am still ultimately liable and responsible for all charges. I understand that it is my responsibility to know the correct amount of my co-payment and deductible. I understand that my co-payments, co-insurance, and any deductibles are due at the time of service. I understand there is a $10 administrative fee if I do not pay my co-payment, co-insurance, and deductible at the time of service, and a separate $10 administrative fee each time a bill is generated for payment due, but not paid at the time of service. I understand I will be charged a "no-show" fee for any missed appointment, or any appointment not cancelled more than 48 hours in advance.

I authorize NCF to release my medical records (protected health information) to my treating physicians and other healthcare providers and to discuss my care with those providers, as my physician deems necessary. I authorize NCF to contact the people whom I list as emergency contacts in the event of an emergency. I authorize NCF to obtain contact information from my other health care providers, my emergency contacts, my employer or my health insurance carrier, if NCF is unable to contact me directly for any reason. I authorize my treating NCF physician to provide information to my caregiver or a family member, if my physician judges this disclosure to be important for my well-being. I authorize NCF to leave messages for me on answering devices attached to my telephones or to contact me by email or text message. I authorize NCF to contact me by email to inform me that information is available for me on the NCF secure patient portal. These authorizations may be revoked by me at any time in writing. I agree that a facsimile or a scanned copy of this agreement may be treated as an original for all purposes. I take these actions in Fairfax County, Virginia.

I acknowledge I have received a copy of the Neurology Center of Fairfax, Ltd.'s Notice of Privacy Practices dated February 28, 2023. I have read, I understand, and I agree to the terms and conditions specified in the Notice of Privacy Practices.

Signature:______________________________ **Date: ________________________**

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****If the patient is under the age of 18, please complete the following:**
The undersigned is a parent/guardian of the patient and executes this form on behalf of the patient.

Name:____________________________________ Relationship: ____________________

Signature:_________________________________ Date: __________________________

For Patients Who Do Not Have Their Insurance Card, and/or Referral, If Required, (includes Work Comp)

I acknowledge that I did not bring a referral as required by my insurance company and/or do not have my insurance card. I am electing to be seen today and agree to pay in full today for the services rendered today since I do not have a valid referral and/or insurance card, or worker's comp authorization.
Signature:____Date: ________________________

ELECTROENCEPHALOGRAPHY TEST (EEG) INSTRUCTIONS

Please arrive 20 minutes prior to the time of your test.

Please read all instructions thoroughly and refer to your order for the test for which you are scheduled.

An Electroencephalogram (EEG) is a recording of electrical activity produced from the brain. Approximately 21 disc electrodes are placed onto your scalp with sticky conductive paste and two EKG electrodes are placed on your chest to record your heart rate simultaneously. There are two activation procedures performed.

1. A strobe light will be placed in front of your face over your closed eyes, and will flash for approximately three minutes, in increasing frequencies every ten seconds.
2. Perform 3 minutes of deep breathing (unless you are unable due to health reasons).

The remainder of the test is performed while you are resting or sleeping.

IMPORTANT (please refer to your test order)

1. **ROUTINE EEG (EEG) or ROUTINE EEG with T1 T2 Leads** *(allow approximately 1.5 hours)*
   Only have **6 hours of sleep** the night before the test and refrain from caffeine (i.e. coffee, tea, chocolate) on the day of the test.
2. **SLEEP DEPRIVED EEG (SDTT)** *(allow approximately 1.5 hours)*
   Only have **4 hours of sleep** the night before the test, in order to be able to sleep during the testing. Refrain from caffeine (i.e. coffee, tea, chocolate) on the day of the test.

PATIENT INSTRUCTIONS:

- **A. HAIR CARE:** Wash and dry your hair thoroughly the day of the test. **Do not use any hair products** (hairspray, oils, gel, etc.) because they may impact the quality of the test. **NO dreadlocks, hair extensions, cornrows, or attached toupees**, as they may impact the placement of the electrodes in the required areas and may cause your appointment to be rescheduled.
- **B. MEDICATIONS:** Please take all your medications unless otherwise instructed by your physician.
- **C. MEALS:** No caffeine the day of your appointment (coffee, chocolate, colas, etc.). Decaffeinated beverages are allowed. Otherwise, please eat your regular meals.
- **D. ILLNESS:** If you are coughing or sneezing in excess due to illness and/or allergies, please reschedule your appointment, as this impacts the quality of the test.
- **E. CLOTHES**: Wear a shirt with a loose opening at the neck. No turtlenecks.

> **SEDATIVE:** ***If you are given a mild sedative (melatonin, an over-the-counter sleep aid) to help you sleep during the sleep deprived EEG test performed in the office, you cannot drive for 8 hours following the test and will require a driver to drive you home.***

Please allow 10 business days for the results of this test to be available to your doctor.

Please do not bring children to testing appointments.

A $100.00 fee is charged for all appointments missed or not cancelled 48 hours in advance.

AMBULATORY ELECTROENCEPHALOGRAM (EEG) INSTRUCTIONS

Please arrive 20 minutes prior to the time of your test.

Please read all instructions thoroughly and refer to your order for the test for which you are scheduled.

An EEG is a recording of electrical activity produced from the brain which is collected by approximately 21 disc electrodes that are placed on your scalp. Two EKG electrodes will also be placed on your chest to record your heart rate simultaneously during the EEG. If you are scheduled for a Routine or Sleep Deprived EEG along with an Ambulatory study, there will only be one application of electrodes. The electrodes are attached using collodion. A one-hour EEG recording will be performed in the office prior to the Ambulatory EEG. An Ambulatory EEG is an extended recording of the electrical activity produced from the brain.

You will then go home with the electrodes attached to your scalp. The electrodes will remain attached for 24, 48 or 72 hours (as ordered). The electrodes are connected to a portable computer that will go home with you in a portable pouch, with a shoulder strap for easy carrying. You will be given a diary to record your activities and symptoms during the study.

AMBULATORY EEG *(allow 1.5 hours)* **/ EEG WITH AMBULATORY EEG:** *(allow 2.5 hours)***:**

WARNING: ELECTRODE REMOVAL *(allow 30 minutes)*. When returning to have the electrodes taken off, a special solvent is used to remove the electrodes. **This solvent is oily. Your hair will be very oily after the electrodes are removed and will require shampooing.**

THIS SOLVENT CAN DAMAGE ITEMS SUCH AS PLASTIC ON EYEGLASSES, HEARING AIDS AND COCHLEAR IMPLANT DEVICES. DO NOT WEAR THESE OR ANY PLASTIC ITEM DURING REMOVAL OF THE ELECTRODES AND UNTIL YOU ARE HOME AND HAVE FULLY SHAMPOOED OUT THE SOLVENT FROM YOUR HAIR.

PREPARATION:

Please get only 6 hours of sleep the night before FOR A ROUTINE T1 T2 EEG OR only 4 hours of sleep the night before a SLEEP DEPRIVED EEG. Refrain from caffeine on the day of testing (coffee/tea/chocolate, etc.).

SEDATIVE: ***If you are given a mild sedative (melatonin, an over-the-counter sleep aid) to help you sleep during the sleep deprived EEG test performed in the office, you cannot drive for 8 hours following the test and will require a driver to drive you home.***

IMPORTANT INSTRUCTIONS FOR ALL AMBULATORY EEG RECORDINGS:

A. ***CLOTHING: Wear a top that buttons or zips down the front or back.*** Once the electrodes are attached, you will not be able to take anything off over your head. Bring a bandanna, do-rag, or **thin** scarf to secure the electrodes on your head. Wear a shirt with a loose opening at the neck. No turtlenecks.

B. **HAIR CARE:** Wash and dry your hair thoroughly the day of the test. **Do not use any hair products** (hairspray, oils, gel, etc.) because they may impact the quality of the test. **NO dreadlocks, hair extensions, cornrows, or attached toupees**, as they may impact the placement of the electrodes in the required areas and may cause your appointment to be rescheduled.

C. **DO'S AND DON'TS:** Do not tamper with the recorder or get it wet (**no shower or bath**). Do not brush your hair, sit under a ceiling fan, or allow wind to blow through your hair. Do not sleep with an electric blanket turned on or in a waterbed with the heater on. Do not chew gum or do excessive snacking (eating chips/ice/peanuts etc.) while wearing the recorder.

D. **DAILY ROUTINE:** Maintain your usual daily routine (eating, sleeping, watching TV, and working on your computer), however, you should **avoid strenuous physical activity**. There are no dietary or medication restrictions. Please no snacking between meals. You may go to work unless your job is physically active. If you have any questions about your activities, please ask.

E. **Diary:** Entries should include a record of your activities from start to end (see example below). Any physical symptoms (blackouts, seizures, spells, dizziness, chest pain, burst of emotion (sad, anger, etc.), or anything you feel to be important and out of the ordinary should be entered in the symptoms area. Record in blocks of time as symptoms occur.

BRING THE DIARY BACK TO THE DOCTOR'S OFFICE AT YOUR ELECTRODE REMOVAL APPOINTMENT.

Sample log:

Time	**Activity**	**Symptoms**
10:00am - 12:00pm	Arrive Home - watch TV	Headache
12:00pm - 12:30pm	Lunch	Body jerk

Please allow 10 business days for the results of this test to be available to your doctor.

Please do not bring children to testing appointments.

A $100.00 fee is charged for all appointments missed or not cancelled 48 hours in advance.

EVOKED POTENTIAL TEST INSTRUCTIONS

Please arrive 20 minutes prior to the time of your test.

Please read all instructions thoroughly and refer to your order for the test for which you are scheduled.

Evoked Potential studies evaluate disorders of the sensory pathways of the nervous system.

Evoked Potential Tests show how well the body's electrical signals travel through the sensory pathways of the nervous system, in response to a specific external stimulus. Brief electrical stimulations are applied and hundreds of responses are received, amplified and averaged by a special computer. Electrodes are placed on your scalp with a sticky conductive paste. The final averaged response is plotted on a graph in the form of a wave or waves, which are evaluated by the neurologist.

PATIENT INSTRUCTIONS FOR ALL EVOKED POTENTIAL TESTS:

1. **HAIR**: Hair should be clean and thoroughly dry. **NO HAIR PRODUCTS SHOULD BE USED** (hairspray, oil, gel, etc.) **NO WEAVES, BRAIDS, HAIR EXTENSIONS, CORN ROWS, OR ATTACHED TOUPEES** (*this may cause your test to be rescheduled.*)
2. **LOTION**: Please do not use body lotion or powder on the day of the test.
3. **MEDICATION**: You should continue taking your normal medications.

VER (VISUAL EVOKED RESPONSE) *Allow 30 minutes*
Visual Evoked Responses evaluate the visual nervous system. Five electrodes are attached to the scalp. The patient will focus on a checkerboard pattern on a computer monitor. The checkerboard pattern is the stimulus and the recording is made through the scalp electrodes. **IF YOU WEAR GLASSES OR CONTACT LENSES, YOU NEED TO WEAR THEM DURING THE TEST.**

BAER (BRAINSTEM AUDITORY EVOKED RESPONSE) *Allow one hour*
Brainstem Auditory Evoked Responses evaluate the auditory nervous system including the brainstem. Two electrodes are attached to the scalp, and one on each ear lobe. Earphones are then placed over the ears and a series of clicking sounds are delivered to each ear separately. The clicking sound is the stimulus and the recording is made through the scalp electrodes.

SSEP (SOMATOSENSORY EVOKED POTENTIAL)
Somatosensory Evoked Potentials evaluate the nerve pathways from the peripheral nerves through the spine to the somatosensory region of the brain (somato-body, sensory-reception). Electrodes are attached to the scalp as well as various points along the nerve pathway from arm or leg to the brain. A small electrical current is applied to the skin over a nerve on the arms or legs and the recording is made through the attached electrodes.

A. **SSEP-arms (MEDIAN/ULNAR NERVE SOMATOSENSORY EVOKED POTENTIAL)** *Allow one hour*
Electrodes will be placed on the shoulders near the neck area, on the back of the neck, and head. Please wear an open-necked top with short sleeves. **DO NOT** use body lotion on your arms or neck.

B. **SSEP-legs (POSTERIOR TIBIAL SOMATOSENSORY EVOKED POTENTIAL)** *Allow one hour*
Electrodes will be attached to your legs, back and head. Please bring shorts/skirt to wear during testing. DO NOT use body lotion on your legs or back.

AUDIOGRAM: *Allow 30 minutes*
No preparation required. Routine hearing test.

Please do not bring children to testing appointments.

A $100.00 fee is charged for all appointments missed or not cancelled 48 hours in advance.

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VASCULAR TESTING

PATIENT INSTRUCTIONS

The Vascular Laboratory at the Neurology Center of Fairfax is a diagnostic non-invasive vascular ultrasound facility. The Vascular Laboratory is a very specialized diagnostic testing facility. Arterial and venous diagnostic studies are performed to detect vascular disease. Cerebrovascular, peripheral arterial, aortic, renal, and venous examinations are performed.

Non-invasive ultrasound is the most important tool in the vascular laboratory. Ultrasound machines are used to take pictures of blood vessels and blood flow in these vessels with color Doppler and pulsed Doppler. Segmental pressures and pulse volume recordings are performed to locate the area of blockage in the arms and legs.

Testing in a vascular laboratory is often the first step in diagnosing vascular disease. Specific tests are performed according to the suspected vascular problems. These procedures are generally painless and can help to determine if blood vessel disease is present, the location, and severity.

The Laboratory is certified by the Intersocietal Commission for the Accreditation of Vascular Laboratories. This is the national certifying body for non-invasive vascular diagnostic laboratories. All testing is performed according to standard recognized protocols approved by the Intersocietal Commission for the Accreditation of Vascular Laboratories. All equipment is current state-of-the-art and is maintained with service contracts from the manufacturing company.

ULTRASOUND INSTRUCTIONS

Please arrive 20 minutes prior to the time of your test.

YOU MUST BRING THE TEST ORDER FROM YOUR DOCTOR

Please read all instructions thoroughly.

Ultrasound Studies Evaluate Your Blood Vessels and Blood Flow.

Carotid Artery and Temporal Artery Studies:

1. No special preparation required.

Upper and Lower Extremity, Arterial and Venous Studies:

1. No special preparation required.

Preparation for Abdominal Vascular Ultrasound Studies:

Renal Arteries, Aorta, and other blood vessels of the abdomen

1. Avoid food and drink, except for noncarbonated water 6 hours before the examination.
2. Do not drink any carbonated beverages 4 hours prior to your test.
3. You may take your usual medications on the day of the examination.
4. If you are diabetic, please take your insulin.
5. Do not chew gum on the day of the examination.

Preparation for Bladder Volume Ultrasound Studies:

1. Empty your bladder 1.5 hours prior to the appointment.
2. Drink 32 ounces of noncarbonated water within 30 minutes.
3. Drink all water 1 hour prior to the appointment.
4. Do not urinate until the examination is finished.
5. You may take all your normal medications as scheduled.

(If your appointment is at 9 am, empty your bladder at 7:30 am, drink all your water by 8:00 am, one hour prior to your appointment.)

If your insurance company requires an insurance referral be sure you have obtained this prior to the time of your appointment.

Please do not bring children to testing appointments.
A $100.00 fee is charged for all appointments missed or not cancelled 48 hours in advance.