MEADVILLE MEDICAL CENTER | MORE THAN A HOSPITAL
1034 Grove Street
751 Liberty Street
Meadville, PA 16335
(814) 333-5000
www.mmchs.org

O.A.M.
Orthopedic Associates of Meadville
11277 Vernon Place, Suite 200
Meadville, PA 16335
Phone: (814) 724-1252
Fax: (814) 337-6043

AMBOAMCONSENT

Name: _____
Medical Record#: _____
Date: _____

CONSENT for ELECTRO DIAGNOSTIC TESTING

"This consent form covers all areas that can be tested. Not all information may pertain to your particular test. **I understand that I am being referred for Electro Diagnostic testing, (commonly termed EMG and nerve conduction studies) to try to clarify the cause of my symptoms.**

What happens to me if I have this test? Small wires will be taped to your skin and you will experience sensations as your nerves and muscles are stimulated. The discomfort of the electrical impulses is mild. There are no after side effects from this electrical stimulation. The other portion of the testing includes the placement of a small pin (similar to an acupuncture needle) in a number of my muscles. This part of the examination involves no electrical stimulation, but it allows us to record the electrical activity which is normally present in the muscles. A number of muscles will be examined in this way and the precise amount of testing depends upon what is found as the examination progresses. The entire procedure generally takes between 30 and 45 minutes.

What are the risks? CARDIAC PACEMAKER: There are very minimal risks from the electrical stimulation if you have a cardiac pacemaker or defibrillator. You should inform the doctor and any staff about the presence of your pacemaker. Certain measures may be taken to reduce the risks.

Bleeding: If you are taking blood thinning medicine, then you have a slightly increased chance of bleeding as a result of the needle placement within your muscles. Even if you are not taking any of these medications, there is a risk of bleeding within the muscle or beneath the skin. (this is minimal and usually heals by itself within a few days) There is also a small risk of infection or localized pain or bruising. You do not need to stop your medications).

Chest Muscles: If the testing requires placing a needle in any of muscles around your chest wall or diaphragm, there is a risk that air could enter the area around your lung and cause pain or difficult breathing. This problem usually heals by itself, but occasionally a small tube must be placed to evacuate the air, since in rare instances the pressure of air can be life threatening.

What are the benefits of this test for me?
The benefit to you from this testing is the possibility that more information will result which will help to clarify your diagnosis. It would then be possible that specific treatment might become available but there are no guarantees. The procedure itself is diagnostic and not therapeutic.

What are my alternatives?
There are no other tests which will provide the information derived in the examination. However, you may decline to have this test and your physician may choose to order different kinds of tests or go no further in your evaluation. If you give consent to proceed, you may withdraw that consent at any time during the examination.

If you choose to give informed consent, then you do so under no sense of duress or coercion. If you decide to withdraw my consent, this will not adversely affect your future medical care.

The undersigned hereby agrees that any dispute or litigation commenced in connection with or as a result of the care provided to the undersigned at MMC shall be filed only in Crawford County, and further agrees that venue for any such dispute or litigation shall rest exclusively within said county.

Patient Signature: _____ Date: _____ /Time: _____
(PLEASE SIGN AND BRING WITH YOU TO YOUR APPOINTMENT)

Physician Signature: _____ Date: _____ /Time: _____

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A M B O A M N E W P T

OAM HIPAA Form

Form #90439
Rev 01/22

Name: _____
Medical Record#: _____
Date: _____

Patient Name _____
Date of Birth _____

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change its privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.

I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: _____ **Signature:** _____ Date: _____

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P,C. to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders (including return telephone calls)
_____ Prescription Refills
_____ Test Results
_____ **Do not leave message**
_____ Permission to fax work status reports to employer
_____ Permission to fax gym/school excuses to school

Signature _____ Date _____

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature _____ Date _____