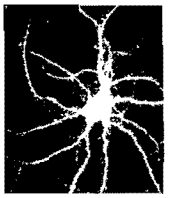

NEURO-TECHNOLOGY INSTITUTE

INFORMED CONSENT FOR INTRAOPERATIVE NEUROMONITORING:

I authorize Neuro-Technology Institute (NTI) to provide intraoperative neuromonitoring as requested by the physician performing my surgical procedure. I understand that I have the right to informed consent, which means my surgeon, authorized representative, or NTI neurophysiologist will explain the monitoring process and answer any questions I may have in regard to the performed procedures. Testing modalities include but are not limited to: SSEPs, EMGs, EEG, TcMEPs, BAERs, and/or Nerve Conduction Studies.

ASSIGNMENT OF BENEFITS: In consideration of the medical services to be provided to me, I hereby promise to pay for the services in accordance with the rates and terms now in effect at NTI to the extent that I am legally responsible. I hereby assign NTI any and all benefits and all interests and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policy or prepaid healthcare plan. I acknowledge that any balance not covered or paid by such policy or Worker's Compensation is my legal responsibility. I authorize the release of information to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing Medicare/Medicaid claims. I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services rendered to NTI. I agree that any charges not covered by Medicare/Medicaid, for any reason, are my responsibility to pay upon receipt of invoice.

AGREEMENT TO PAY FOR SERVICES: The undersigned agrees (whether he/she signs as agent or patient) that consideration of services rendered to the patient be taken and agree to pay for requested services in accordance with the rates and terms of NTI at the time services are provided.

AUTHORIZATION TO RELEASE INFORMATION: I authorize NTI to have full and complete access to my medical records and surgical chart from hospital and or physician. Furthermore, I authorize NTI to furnish requested information from my medical and other records to any insurance or third party payer for the purpose of obtaining payment on the account; to any other persons or entities financially responsible for my care or treatment; representatives of local, state, or federal agencies in accordance with applicable law. I furthermore authorize NTI to release information or copies of my medical records to any referring physician or to any healthcare facility to which I may be transferred.

ASSIGNMENT OF RIGHTS: I,_____hereby assign to NTI, to the full extent allowed by law, the right to collect the unpaid insurance benefits, penalties, attorney's fees, court costs, and all other recoverable damages of any nature from the medical insurance company that provided coverage on the date listed herein. This assignment includes the right to bring to litigation the insured's medical insurance company in the insured's name and assert all claims that the insured will have against the insurance company result from, or in any way pertaining to, the medical coverage that the insured is alleged to have had with his/her insurance company in regard to medical procedures performed on_____. The insured agrees to cooperate with NTI in providing documents and testimony concerning the rights assigned herein.

The undersigned certifies that he/she has read and understands this consent form and fully understands his/her rights as stated herein, and is fully authorized as the patient or patient's authorized representative to execute the above and accept the terms as stated above.

_____ _____

Patient name (print) Date

_____ _____

Patient signature Witness

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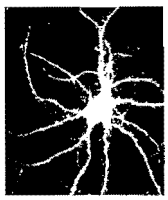

NEURO-TECHNOLOGY INSTITUTE

COMMUNICATION LOG/OR NOTES:

PATIENT STICKER:

SURGEON: _____ DATE OF SURGERY: _____

PATIENT HISTORY:

__PROCEDURE: _____

__SURGERY HX: _____

__DIAGNOSIS: _____

__SYMPTOMS: _____

__HOW LONG? _____

__DIABETIC? _____ ANY WEAKNESS? _____

SURGICAL NOTES:

__*PRE-INCISION ANESTHESIA:* _____ PEDICLE SCREW STIM: _____

__TEMP: _____ *LEFT* _____ *RIGHT* _____

__BP: _____

__HR: _____

__GAS: _____

__PARALYTICS USED: _____

ANY CONTRAINDICATIONS FOR TCMEP? PACEMAKER? BURR HOLES?

HX OF SEIZURES? CRANIAL IMPLANTS? ANY METAL IN HEAD?

BITE BLOCK PLACED BY CRNA?

INTERPRETATION NOTES:

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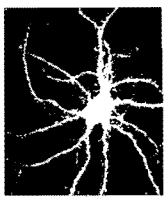
Phone: 1.225.293.6222 • Fax: 1.225.208.1100



NEURO-TECHNOLOGY INSTITUTE

CERTIFICATE OF MEDICAL NECESSITY:

PATIENT STICKER:

DATE OF SURGERY:

HOSPITAL:

INTERPRETING MD:

DIAGNOSIS/ICD-9

PROCEDURE:

MONITORING TIME:

Start	Stop	Hours

CPT CODES AND DESCRIPTIONS:

	95941/G0453	Intraoperative Monitoring (per hour)	
	Medicare	Date	
	95925	SSEP	Upper Limb
	95926	SSEP	Lower Limb
	95938	SSEP	Both Upper and Lower
	95927	SSEP	Cortical (stim brain or trunk)
	95928	TcMEP	Upper Limb
	95929	TcMEP	Lower Limb
	95939	TcMEP	Both Upper and Lower
	92585	BAER	
		Total NCS	Pedicle Screw, H-Reflex, Direct Nerve Stim, Pop Fossa, etc.
	51785	EMG	Anal Sphincter
	95867	EMG	Cranial Nerve Unilateral
	95868	EMG	Cranial Nerve Bilateral
	95860	EMG	One Limb
	95861	EMG	Two Limbs
	95863	EMG	Three Limbs
	95864	EMG	Four Limbs
	95870	EMG	Non-Limb
	95829	Electrocorticography	
	95961	Cortical Mapping (first hour)	
	95962	Cortical Mapping (additional hours)	
		Procedures not listed, note below	

NERVES MONITORED FOR SSEPS:

___ Median Nerve	___ Ulnar Nerve
___ Posterior Tibial Nerve	___ Peroneal Nerve

MUSCLES MONITORED FOR CRANIAL EMG:

___ Masseter	___ Stylopharyngeus
___ Orbicularis Oculi	___ Vocalis
___ Orbicularis Oris	___ Upper Trapezius
___ Mentalis	___ Tongue

MUSCLES MONITORED FOR EMG:

___ Sternocleidomastoid	___ Iliopsoas
___ Trapezius	___ Adductor Magnus
___ Deltoid	___ Vastus Medialis
___ Bicep	___ Vastus Lateralis
___ Tricep	___ Rectus Fermoris
___ Brachial radialis	___ Tibialis Anterior
___ Flexor Carpi Ulnaris	___ Gastrocnemius
___ Abductor Pollicis Brevis	___ Extensor Hallucis Brevis
___ Abductor Digiti Minimi	___ Adductor Hallucis

MUSCLES MONITORED FOR NON-LIMB EMG:

___ Intercostal Multi-level	___ Abdominal Multi-level

SUPPLIES:

	A4212	Needles
	A4556	Electrodes (per pair)
	A4557	Lead Wires (per pair)
	A4558	Paste/Gel

I have requested the monitoring services listed above for this procedure in order to reduce the risk of neurological deficits that may occur during surgery. I certify that I have reviewed the services documented in this form and that I deem them medically necessary for the patient listed.

Surgeon Name (print)	Surgeon Signature	Date
Electro Neuro Diagnostic Technician Name	Electro Neuro Diagnostic Technician Signature	Date

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