

University Neurology Cole Neuroscience Center  
2200 Sutherland Avenue  
Cherokee Mills  
Knoxville, TN 37919

**APPOINTMENT DATE:**

**ARRIVAL TIME:**

***You will find directions to our office on the back of this page.***

## **ELECTROMYOGRAPHY STUDY (EMG) NERVE CONDUCTION STUDY (NCS)**

### **What is an EMG and NCS?**

These tests evaluate the muscle and nerve function in specific areas of your body, usually the arms or legs. The test helps your doctor decide if pain, loss of normal feeling, or weakness in a part of your body is caused by problems in the muscles or nerves to that area.

### **How do I prepare for the test?**

Wash the arm(s) or leg(s) to be tested before you come. Do not use oils, creams, or lotions.

Tell the technician if you have a pacemaker so adjustments in the test can be made. A specialist will interpret the results of the test and a report will be sent to your doctor within five business days. If you have any questions, please ask your doctor.

### **EMG (Electromyography)**

This test measures electrical impulses of the muscles and nerves in the arms and legs. A small needle is placed into several muscles, one at a time to record the natural activity of your muscle. You will probably find that the needles are not as uncomfortable as you might expect.

### **NCS (Nerve Conduction Studies)**

This test is performed by giving small electrical shocks, and measuring how quickly electrical pulses travel along the nerve. The shocks are uncomfortable, but cannot hurt you.

Phone (865)521-6174  
Fax (865)546-4065

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**From I-40 Going East**

- Take Exit 386B Alcoa HWY (HWY 129)
- Take the Kingston Pike Exit (Route 70)
- Turn right (West) on to Kingston Pike
- The next red light is the intersection of Kingston Pike, Concord Street and Neyland Drive, take a right on to Concord Street
- The Next red light is the intersection of Concord Street and Sutherland Ave

Our building is on the left, you may enter the parking lot from Concord Street or Sutherland Avenue

**From 275 South or I-40 Going West**

- Take Exit 386B Alcoa Highway (HWY 129)
- Take the Kingston Pike Exit (Route 70)
- Turn right (west) on to Kingston Pike
- The next red light is the intersection of Kingston Pike, Concord Street, and Neyland Drive, Take a right on to Concord Street.
- The Next red light is the intersection of Concord Street and Sutherland Ave

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**From Maryville**

- Take Alcoa Highway (HWY 129) North
- Take the Kingston Pike Exit (Route 70)
- Turn Left (west) on to Kingston Pike
- The next red light is the intersection of Kingston Pike, Concord Street, and Neyland Drive, take a right on to Concord Street
- The Next red light is the intersection of Concord Street and Sutherland Ave

Our building is on the left, you may enter the parking lot from Concord Street or Sutherland Avenue

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***DUE TO POSSIBLE TRAIN DELAY NEAR OUR LOCATION, WE HAVE INCLUDED AN ALTERNATE ROUTE***

**From I-40 Going East**

- Take exit 386A
- Continue straight to Middlebrook Pike and Sutherland Ave Intersection
- Go Straight on to Sutherland Avenue 0.9 miles

**CHEROKEE MILLS/UNIVERSITY NEUROLOGY COLE NEUROSCIENCE CENTER WILL BE ON YOUR LEFT.**

**From 275 South or I-40 Going West**

- Use the right lane to take exit 386B for U.S. 129/Alcoa Hwy
- Keep right
- Turn left on to Sutherland Avenue
- At the intersection of Middlebrook Pike and Sutherland Avenue, continue straight 0.9 miles

**CHEROKEE MILLS/UNIVERSITY NEUROLOGY COLE NEUROSCIENCE CENTER WILL BE ON YOUR LEFT.**

**From Maryville**

- Take Alcoa Highway (HWY 129) North
- Continue straight passing the Kingston Pike exit
- Staying right go toward 40/275 East/North
- Than take the 17<sup>th</sup> Street Western Avenue Exit
- At the stop sign, turn left on to Twenty First Street
- Second red light, turn left on to Middlebrook Pike
- At the next light turn left on to Sutherland Avenue
- Continue straight 0.9 miles

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## Patient Privacy Questionnaire and Notification

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

**Contact Information:**

I would prefer to be contacted at: \_\_\_\_\_ Home # \_\_\_\_\_  
\_\_\_\_\_ Cell # \_\_\_\_\_  
\_\_\_\_\_ Work # \_\_\_\_\_  
\_\_\_\_\_ Other # \_\_\_\_\_

\_\_\_\_\_ May ONLY leave information with me. (If you check here, no other choice should be marked).

\_\_\_\_\_ May leave appointment reminders on my answering machine/voicemail.

\_\_\_\_\_ May leave lab results on my answering machine/voicemail.

\_\_\_\_\_ May leave general questions/information on my answering machine/voicemail.

\_\_\_\_\_ May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ May leave appointment reminders with the above listed person

\_\_\_\_\_ May leave lab results with the above listed person

\_\_\_\_\_ May leave general questions/information with the above listed person

\_\_\_\_\_ May discuss billing information with the above listed person

\_\_\_\_\_ I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number
<b>PATIENT INFORMATION</b>		
Social Security #		Date of Birth
First Name	Middle	Last Name
Home Address		City State Zip
Email Address		Race _____ Ethnicity _____
Gender (Circle as many as are appropriate)		
Birth Sex: Male Female Transgender Other		
Current Sex: Male Female Transgender Other		
Marital Status	Married Single	Home Phone ( )
(Circle One)	Divorced Widowed	Cell Phone ( )
(Circle One)	Employed Retired Disabled	Work Phone ( )
	F/T Student Other	
Employer		Referring Physician
How did you hear of us?		
<b>PRIMARY INSURANCE INFORMATION</b>		
<b>PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST</b>		
Insurance	ID #	GR #
Name of Insured	DOB	SS#
<b>SECONDARY INSURANCE INFORMATION</b>		
Insurance	ID#	GR #
Name of the Insured	DOB	SS#
<b>EMERGENCY CONTACT</b>		
Relationship		
First Name	Middle	Last
Home Phone ( )	Work Phone ( )	Cell ( )
<b>SPOUSE/GUARANTOR/RESPONSIBLE PARTY</b>		
Social Security #	Sex	Date Of Birth
Relationship		Daytime Phone ( )
First Name	Middle	Last Name
Address		City State Zip
Employer	Address	
City	State	Zip

**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:** I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

<b>SIGNATURE</b> (Patient or Parent if Minor)	DATE
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