Patient Consent Form for General Exams & Medical Procedures

Patient Name: _____
Date of Birth: _____

I voluntarily consent to receive medical care and treatment at Beachside Neurology, including but not limited to:

- Physical exams, routine check-ups, and diagnostic assessments
- Minor office-based treatments (e.g., wound care, suture removal, joint injections, etc.)
- Other medically necessary procedures as determined by my provider

I understand that medical treatment may involve risks, including but not limited to allergic reactions, side effects, or discomfort. I acknowledge that my provider will discuss any significant risks associated with my care before proceeding.

☐ I consent to general medical exams and treatments.
☐ I decline general medical exams and treatments.

If my provider determines that I require a specific medical procedure, I consent to the following:

General Medical Procedures

- Minor in-office procedures (e.g., skin biopsies, joint injections, trigger point injections)
- Pain management treatments
- Diagnostic testing

Electromyography (EMG) and Nerve Conduction Studies (NCS)

I consent to undergoing EMG and NCS, which are used to evaluate nerve and muscle function.

I understand that:

- EMG involves inserting small needles into muscles to measure their electrical activity.
- Nerve conduction studies involve applying small electrical impulses to assess nerve function.
- Potential risks include mild discomfort, bruising, or temporary soreness. ● I should inform my provider if I have a pacemaker, bleeding disorder, or implanted medical devices.

☐ I consent to EMG and nerve conduction studies.
☐ I decline EMG and nerve conduction studies.

Electroencephalogram (EEG)

I consent to undergoing an EEG, a test that records electrical activity in the brain.

I understand that:

- Small electrodes will be attached to my scalp to monitor brain waves.
- I may be asked to perform certain activities, such as breathing deeply or looking at flashing lights.
- The test is non-invasive and painless, but slight discomfort from the electrodes or gel may occur.
- I should notify my provider if I have a history of seizures, neurological conditions, or scalp sensitivity.

☐ I consent to an EEG.
☐ I decline an EEG.

I understand that I am responsible for any costs not covered by my insurance, including copays, deductibles, and out-of-pocket expenses. I agree to provide accurate insurance information and authorize billing for services rendered.

☐ I understand my financial responsibility.