



Features and Benefits

- Income from testing, benefits your practice not an outside physician or facility
- No start up expense
- **HIPAA & STARK COMPLIANT**
- Provide increased patient convenience and satisfaction
- Generate **substantial revenues** for your practice
- Test at your schedule and convenience
- No additional burden on your staff
- We handle all insurance verification
- 72 hour response to schedule dates nationwide
- Board certified Neurologists and Radiologists
- Billing & reimbursement assistance
- Simple to integrate into the busiest of practices
- We accept PPOs, POSs, Worker's Comp, and PIP, sorry no Medicare and HMO's.

Schedule patients for the following

- Nerve conduction velocity studies (NCV)
- Evoked potentials (SSEP)
- Dermatomal Evoked Potentials (DSSEP)
- Diagnostic Musculoskeletal Ultrasounds



FAX to (888) 395-3941 or Call (888) 395-4007



COMMON CONDITIONS THAT INDICATE NEED FOR DIAGNOSTIC TESTING

- | | |
|---|---|
| <input type="checkbox"/> Peripheral neuropathies | <input type="checkbox"/> Radiculopathies |
| <input type="checkbox"/> Numbness and tingling | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Pain in the extremities | <input type="checkbox"/> Tarsal tunnel syndrome |
| <input type="checkbox"/> Diabetic and ischemic neuropathies | <input type="checkbox"/> Plexopathy |
| <input type="checkbox"/> Entrapment neuropathies | <input type="checkbox"/> Trauma to nerves |
| <input type="checkbox"/> Thoracic outlet syndrome | <input type="checkbox"/> Herniated discs |
| <input type="checkbox"/> Neuromuscular disorders & inflammation | <input type="checkbox"/> Motor/sensory deficits |
| <input type="checkbox"/> Localized back trauma | <input type="checkbox"/> Hot/cold sensation |
| <input type="checkbox"/> Nerve root compression | <input type="checkbox"/> Neuritis |

Yes, I would like to receive more information regarding IPR.

Physician Name _____

Contact Person _____

Phone _____ Fax _____

Mailing Address _____

City _____ State _____ Zip _____

Type of Practice or Specialty _____

E-mail address: _____

Are you currently testing in your office: Yes _____ No _____

Patients referred out for neurological testing per month:

(1-5) (6-10) (11-20) (20 or more)

What is your preferred day for testing?

(Monday) (Tuesday) (Wednesday) (Thursday) (Friday) (Saturday)

How do you wish to receive information?

- Mail
- Fax
- E-mail

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