PARKWAY
NEUROSCIENCE
& SPINE INSTITUTE

Physical Therapy
13 Western Maryland Parkway, **Suite 202**
Hagerstown, MD 21740

Dear Patient:

Your appointment with _____ is scheduled for _____,

_____ at _____ o'clock, in the Physical Therapy office.

Please plan to arrive 15 minutes prior to your scheduled appointment time. The provider is able to see you with completed information including but not limited to our medical staff intake process. Please be patient with us as we will need to review and upload your information securely and accurately into our database. Thank you in advance for your patience and understanding.

Please bring the following items with you the day of the appointment, if applicable:

- Your insurance card(s)
- Your driver's license (or other photo identification)
- The included patient information forms which must be completed in their entirety. If your forms are not completed at the time of arrival, your appointment may be delayed or rescheduled. ***If you prefer to complete your forms on-line through our secure "Patient Portal" please provide your email address to an associate so we may send you an invitation.***
- If a referral is required by your insurance company: "It is the patient's responsibility to obtain and present a referral for services rendered at time of visit. Your insurance company will not allow our provider's to see you without a referral.
- If you are claiming an injury from an auto accident or workman's compensation accident, please bring the following billing information with you:
    - Name, address and telephone number of the insurance company
    - Claim number
    - Authorization number for you consultation

If you do not bring all of the above information, your appointment will be rescheduled.

We accept many insurance plans, HMO's and Medicare. We will submit these claims to your insurance company. We ask that you be prepared to pay any applicable co-payment/co-insurance at the time of service. For your convenience, we accept cash, check, Visa, MasterCard and American Express.

If you have any questions prior to your appointment, please call our office at 301-797-9240 between 8:00 am and 5:00 pm Monday – Friday.

Thank you,

Parkway Neuroscience and Spine Institute, LLC

Location: Parkway Neuroscience & Spine Institute, Physical Therapy is located just west of Hagerstown off Route 40 at 13 Western Maryland Parkway, Suite 202. It is just several blocks from the Centre at Hagerstown Shopping Center and down the street from First Data Corporation.

Directions for: Parkway Neuroscience and Spine Institute, LLC
PHYSICAL THERAPY

Hagerstown, Maryland

13 Western Maryland Parkway, PT – Suite 202

From the North
(Chambersburg, Carlisle and Harrisburg)

- Follow I-81 South to Maryland Exit 6 (Route 40)
- Travel East towards Hagerstown and take the first right onto Western Maryland Parkway
- The Institute is located on your right just past First Data Corporation

From the North (Waynesboro)

- Follow Route 66 (Leitersburg Pike) South to Maryland Rout 40 (Franklin Street)
- Travel West towards I-81 and the Centre at Hagerstown Shopping Center and turn left onto Western Maryland Parkway
- The Institute is located on your right just past First Data Corporation

From the South (Martinsburg, Winchester)

- Follow I-81 North to Maryland Exit 6 (Route 40)
- Travel East towards Hagerstown and take the first right onto Western Maryland Parkway
- The Institute is located on your right just past First Data Corporation

From the West (Cumberland)

- Take I-70 East to I-81 North to Maryland Exit 6 (Route 40)
- Travel East towards Hagerstown and take the first right onto Western Maryland Parkway
- The Institute is located on your right just past First Data Corporation

From the East (Frederick, Shady Grove Germantown)

- Take I-70 West to I-81 North to Maryland Exit 6 (Route 40)
- Travel East towards Hagerstown and take the first right onto Western Maryland Parkway
- The Institute is located on your right just past First Data Corporation

PARKWAY NEUROSCIENCE AND SPINE INSTITUTE, LLC
PATIENT REGISTRATION AND INFORMATION

Patient Information **Today's Date:** _____

Last Name_____ First Name_____ M.I._____
Date of Birth _____/_____/_____ Age_____ Social Security #_____
Address _____
Apartment or Room_____City_____State_____Zip_____
Home# (___) _____Work# (___) _____Ext_____
Cell# (___) _____Email _____

(Please circle above preferred method of contact)

Sex (circle): Male Female Employer_____ Email: _____
Marital Status (circle): Married Single Widow(er) Divorced Separated
Race (check one): ___ American Indian ___ Asian ___Black/African American ___Native Hawaiian
___ Other Pacific Islander ___White ___Prefer not to answer
Ethnicity (check one): ___ Hispanic/Latino ___Not Hispanic ___Prefer not to answer
Preferred Language (check one): ___ English ___Spanish ___Other _____(list) ___Prefer not to answer

Referring Doctor _____Office Phone #(___) _____
Address _____
Primary Care Physician_____ Office Phone #(___) _____
Address _____

Emergency Contact
Name_____ Relationship_____ Phone(___) _____

Do you give our office permission to discuss your medical information with family members? Yes No
If yes, please provide their name and phone number below.
Name: _____ Phone (_____) _____
Name: _____ Phone (_____) _____
May we leave personal medical information on your voice mail? Yes No
May we email personal medical information to you? Yes No
May we email updates, newsletters and general PNSI information to you? Yes No

How did you hear about PNSI? (circle) Ad Flyer Web Friend/Family Family/Referring Physician

Insurance Information

Note - If you have a worker's compensation or auto claim, please also fill in your health insurance information
Section A- Medicare/Medicaid
Do you have Medicare? Yes No If yes, Medicare #_____
Effective date: _____ Is Medicare your primary or secondary insurance? Primary Secondary
Do you have Medical Assistance (Medicaid)? Yes No If yes, Medicaid #_____
Effective date_____ Is Medicaid your primary or secondary insurance? Primary Secondary
Do you have any supplemental insurance? Yes No Insurance_____
ID#_____ Is this primary or secondary? Primary Secondary

Patient Name: _____

Insurance Information continued

Section B- Health Insurance

Insurance Company_____ Referral Required (circle) Yes No
ID #_____ Group_____
Insurance Subscriber_____ Date of Birth ____/____/____
Relationship to Patient_____ Social Security #_____
Subscriber Employer_____ Work # (___) _____
Employer Address_____
Do you have a secondary insurance? Yes No Insurance
Company_____
ID #_____ Group_____
Insurance Subscriber_____ Date of Birth ____/____/____
Relationship to Patient_____ Social Security #_____
Subscriber Employer_____ Work # (___) _____
Employer Address_____

Section C- Automotive Accident Liability Information

Is this injury related to a motor vehicle accident? Yes No If yes, Date of Accident____/____/____
Auto Insurance Carrier_____ Claim #_____
Claims Address_____ Phone # (___) _____
Note – For Automotive Accident claims - If you DO NOT have health insurance you will be responsible for the payment in full at the time of service.

Section D- Worker's Compensation Claim Information

Is this injury related to a work accident? Yes No If yes, Date of Accident____/____/____
Compensation Insurance_____ Claim #_____
Claims Address_____ Phone # (___) _____
Claim Adjuster_____ Employer's Name_____

I, the below signed, certify that the above information is true and correct to the best of my knowledge.

Signature of Patient/Responsible Party:_____ Date: _____

Cancellation Policy

Parkway Neuroscience and Spine Institute, LLC requires 24 hour notice when canceling any appointment. I understand that I will be liable for a charge of $40.00 if I fail to give such notice to cancel a medical appointment, physical therapy appointment or chiropractic appointment and a $100.00 charge for a procedure/surgical appointment. After three charges/violations you may be subject to termination from PNSI.

Return Check Policy

Parkway Neuroscience and Spine Institute, LLC charges $35.00 for all returned checks.

I, the below signed, understand and agree to the terms of the previous information.

Signature of Patient/Responsible Party:_____ Date: _____

PARKWAY NEUROSCIENCE AND SPINE INSTITUTE, LLC
AUTHORIZATION/ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I _____ (Print Name) hereby authorize benefits to be assigned to Parkway Neuroscience and Spine Institute, LLC, ("Provider"), for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company due upon receipt of invoice or statement from Provider, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at 17 Western Maryland Parkway, suite 100, Hagerstown, MD 21740, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

If I am a Medicare or Medigap Benefit Participant I hereby authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or Carriers and/or Medigap insurance carrier, any information needed for this or related Medicare claim. I request PNSI bill claims directly to Medicare and/or Medigap and for payments to be received directly by PNSI. Medigap patients may receive the following message on their Explanation of Benefits: "Because you are assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days." Section 4801 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medigap benefits.

I agree and understand that PNSI will charge and bill me directly for Administrative fees for Miscellaneous Services, including but not limited to, preauthorization for prescriptions and/ or imaging, insurance "Peer to Peer", psychological testing, Chlorhexidine preparation, medical record preparation, disability, motor vehicle and family medical leave forms, telephone consultation services for prescriptions and evaluation and management services.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges, due upon receipt of invoice or statement from Provider, of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Guarantor Date

_____
Witness

PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

Referring Doctor: _____ **Primary Care Dr:** _____

Preferred Pharmacy: (name/location/phone #) _____

CURRENT MEDICATIONS: Please list all

Medication	Dose	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

ALLERGIES:

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please describe the allergy and the reaction: _____

_____

_____

Do you have any other allergies we should know about? ☐ Yes ☐ No

If yes, please describe the allergy and the reaction: _____

FAMILY HISTORY:

Family Member	Alive/Deceased	Age	Medical Problem(s)
Mother	A D		
Father	A D		
Sister/Brother (please circle)	A D		
Sister/Brother (please circle)	A D		
Sister/Brother (please circle)	A D		
Sister/Brother (please circle)	A D		

Are there diseases which are common in your family? (If yes, please list.)_____

_____

Has any family member had a history of surgery for their back or neck, or had problems with their back or neck? _____

_____

_____

Patient Name: _____

SOCIAL HISTORY:

Occupation: _____

A: Physically, do you consider your job: ☐ Heavy ☐ Moderate ☐ Light

B: If retired, what was your prior occupation? _____

Is someone available to care for you in your home if the need arises? ☐ Yes ☐ No

Do you live in a: ☐ House ☐ Apartment ☐ Other: _____ #of stories: 1 2 3

Do you exercise regularly? ☐ Yes ☐ No Describe: _____

Do you have a history of drug abuse or drug addition? ☐ Yes ☐ No

Alcohol use:

I use alcohol: ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

I have a history of heavy alcohol use: ☐ Yes ☐ No

Tobacco use:

Do you smoke? ☐ Yes ☐ No

I currently smoke _____packs per day and have smoked for _____years

Are you at risk for AIDS/HIV (e.g. sexual history, drug use, previous transfusion)? ☐ Yes ☐ No

PAST MEDICAL HISTORY: Please circle yes or no

Y	N	Use of Blood Thinners			
Y	N	Anxiety Disorder	Y	N	Head Injury, without skull fracture
Y	N	Aortic Aneurism	Y	N	HIV
Y	N	Arthritis	Y	N	High Cholesterol
Y	N	Asthma	Y	N	High Blood Pressure
Y	N	Bipolar Disorder	Y	N	Heart Attack
Y	N	Cancer	Y	N	Infectious Diseases (e.g. MRSA, TB)
Y	N	Congestive Heart Failure	Y	N	Osteoarthritis
Y	N	COPD (Chronic Obstructive Pulmonary Disease)	Y	N	Osteoporosis
Y	N	Coronary Artery Disease	Y	N	Rheumatoid Arthritis
Y	N	(CVA) Stroke	Y	N	Seizue Disorder
Y	N	Degenerative Joint Disease	Y	N	Sleep Apnea
Y	N	Depression	Y	N	Thyroid Disease
Y	N	Diabetes	Y	N	Tuberculosis
Y	N	Fibromyalgia	Y	N	Vertebral Artery Stenosis
Y	N	Glaucoma			
Y	N	Head Injury, with skull fracture			

Complications from any surgery? ☐ No ☐ Yes - Please Explain _____

_____

Do you take antibiotics before procedures or dental work? ☐ No ☐ Yes – Why? _____

_____

Patient Name: _____

PAST SURGICAL HISTORY: Please list all previous surgical procedures and the **date** your surgery was performed.

- ☐ Carpal Tunnel _____
- ☐ Craniotomy _____
- ☐ Discectomy _____
- ☐ Endarterectomy _____
- ☐ Intracathecal Pump _____
- ☐ Kyphoplasty _____
- ☐ Laminectomy-Cervical _____
- ☐ Laminectomy-Lumbar _____
- ☐ Spinal Cord Injury _____
- ☐ Spinal Cord Stimulator _____
- ☐ Spinal Fusion – Lumbar _____
- ☐ Spinal Fusion – Thoracic _____
- ☐ Ulnar Nerve Release _____
- ☐ Vertebroplasty _____
- ☐ Other _____

- ☐ Appendectomy _____
- ☐ C-Section _____
- ☐ Gall Bladder Removal _____
- ☐ Dental _____
- ☐ D&C _____
- ☐ Eye Surgery _____
- ☐ Fracture Repair _____
- ☐ Heart Surgery _____
  - ☐ Angioplasty _____
  - ☐ Bypass _____
  - ☐ Stent _____
  - ☐ Valve Replacement _____
  - ☐ Other _____

- ☐ Hernia Repair _____
- ☐ Hysterectomy _____
- ☐ Sinus Surgery _____
- ☐ Pancreatic Surgery _____
- ☐ Prostatectomy _____
- ☐ Large Bowel Resection _____
- ☐ Small Bowel Resection _____
- ☐ Stomach Resection _____
- ☐ Rotator Cuff Repair _____
- ☐ Thyroidectomy _____
  - ☐ Subtotal _____
  - ☐ Total _____
- ☐ Tonsillectomy _____
- ☐ Tubal Ligation _____
- ☐ Vasectomy _____
- ☐ Other _____

REASON FOR VISIT:

Describe your current problem and how it began. Please list all symptoms leading to today's visit: _____

_____

_____

_____

_____

REASON FOR VISIT cont'd:

Date symptoms began: _____

Is your current problem a result of: ☐ Car Accident ☐ Work Accident ☐ Other/Unknown

Date of injury/accident: _____

Are you currently off work because of your problems? ☐ Yes ☐ No

Is a lawyer involved in your case? ☐ Yes ☐ No If yes, name of lawyer: _____

PAIN HISTORY: (if not applicable, skip to next section)

What makes your symptoms better? _____

What makes your symptoms worse? _____

What specific activities are you having difficulty with that you hope to change as a result of treatment? _____

_____

_____

In order to get better, you will be expected to participate in your treatment. This may include doing exercises or avoiding certain activities. How committed are you to participating in your treatment?

☐ Very Committed ☐ Somewhat Committed ☐ Not Very Committed

Is there anything that will limit your ability to participate in therapies? ☐ Yes ☐ No

Please Explain: _____

_____

What tests have you had for your problem? ☐ X-rays ☐ Ct Scan ☐ MRI ☐ Blood Tests

☐ Other: _____

What treatments have you had for your problem? ☐ Medication(s) ☐ Physical Therapy ☐ Chiropractic

☐ Injections ☐ Surgery ☐ Other: _____

Please describe their effect: _____

_____

_____

Would you consider surgery if it were recommended? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Please circle yes or no

General:

Y N Weight gain greater than 10 lbs

Y N Weight loss greater than 10 lbs

Y N Obesity

Skin:

Y N Bruising

Neck:

Y N Neck Mass

Y N Swollen Glands

Respiratory:

Y N Chronic Cough

Y N Difficulty Breathing

PATIENT HEALTH HISTORY

Patient Name: _____

HEENT:

Y	N	Blurred Vision
Y	N	Head Injury
Y	N	Double Vision
Y	N	Visual Disturbances
Y	N	Visual Loss
Y	N	Hearing Loss
Y	N	Ringing in the Ears
Y	N	Seasonal Allergies
Y	N	Hoarseness

Breast:

Y	N	Nipple Discharge

Cardiovascular:

Y	N	Chest Pain
Y	N	Irregular Heart Beat
Y	N	Elevated Blood Pressure
Y	N	Rapid Heart Beat
Y	N	Shortness of Breath
Y	N	Swelling of the Feet

Gastrointestinal:

Y	N	Change in Bowel Habits
Y	N	Indigestion
Y	N	Jaundice
Y	N	Nausea
Y	N	Vomiting

Genitourinary:

Y	N	Change in bladder habits
Y	N	Frequency
Y	N	Hesitancy
Y	N	Incontinence

Musculoskeletal:

Y	N	Back Pain
Y	N	Muscle Cramps
Y	N	Arm Weakness
Y	N	Leg Pain
Y	N	Neck Stiffness

Neurological:

Y	N	Decreased Memory
Y	N	Difficulty Speaking
Y	N	Dizziness
Y	N	Fainting
Y	N	Headaches
Y	N	Incoordination
Y	N	Loss of Consciousness
Y	N	Seizures
Y	N	Stroke
Y	N	Weakness in Extremeties
Y	N	Leg Pain with Walking

Psychiatric:

Y	N	Anxiety
Y	N	Depression
Y	N	Inability to Concentrate

Endocrine:

Y	N	Thyroid Problem

Hematology:

Y	N	Abnormal Bleeding
Y	N	Anemia
Y	N	Blood Clots

Other: _____

_____

The above information is accurate to the best of my knowledge:

_____ _____ _____

Please Print Name Signature Date

I HAVE REVIEWED THE ABOVE INFORMATION ***(Office Use Only)***

_____ _____ _____

Physician Name Signature Date Reviewed

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please review the "Patient Notice of Privacy Practices" prior to signing this document. Should you have any questions or comments please see an associate for assistance. Parkway Neuroscience and Spine Institute, LLC, ("PNSI") reserves the right to modify the privacy practices outlined in the notice.

EFFECTIVE DATE OF NOTICE: JULY 29, 2013

I have received a copy of the Notice of Privacy Practices for Parkway Neuroscience and Spine Institute, LLC

Signature of patient or patient's representative: _____

Date: _____

Printed name of patient's representative: _____
Relationship to patient: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Parkway Neuroscience and Spine Institute, LLC, ("PNSI") creates and maintains health records describing my health history. I understand that PNSI may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payors can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to PNSI's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of PNSI. In addition, I acknowledge that I received on the date indicated below a copy of PNSI's Notice of Privacy Practices, which describes the obligations of PNSI regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that PNSI reserves the right to change its notice and practices. If PNSI changes the notice, I can obtain a revised copy by asking the chief operating officer of PNSI. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that PNSI is not required to agree to the restrictions requested, except that PNSI must grant a request to restrict disclosure of my health information for payment or health care operations purposes if the disclosure is to a health plan and the health information relates solely to a health care item or service for which PNSI has been paid out of pocket by me in full. If PNSI does agree to any additional restrictions, PNSI must comply with such restrictions.

_____ I request the following restrictions to the use or disclosure of my health information.

_____

_____

EFFECTIVE DATE OF NOTICE: JULY 29, 2013

Signature of patient or patient's representative: _____

Date: _____

Printed name of patient's representative: _____
Relationship to patient: _____