MCNERNEY & ASSOCIATES, P.A.

Thank you for choosing McNerney and Associates, P.A. to provide your therapy care. Our physical therapists specialize in the use of gentle manual techniques and use of specific exercises to help restore function in most orthopedic and spine-related pain conditions, as well as in those conditions that are associated with vertigo, balance deficits and Fall Risk.

Please call our office before your visit to confirm that we participate with our insurance plan or decide if you wish to be treated out the network or out of plan. We are participating providers with Medicare, all Carefirst products, Aetna except the HMO, Cigna, Allegiance, PHCS, Evergreen, EHP and most Tricare plans.

Our treatment schedules fill quickly, so please plan to make follow up visits at the time of your first visit, or prior to your first visit. Follow up appointments are typically only scheduled 6 weeks out.

If you need to cancel and appointment, please do so as soon as possible. We require 24 business hours prior notice to cancel an appointment. We are not open on weekends, so please call to cancel Monday appointments on Fridays. Failing to abide by your cancellation policy may result in a fee:

- $25.00 for follow up missed appointments less than 24 hours'
- $50.00 for initial appointment missed or cancelled less than 24 hours'

For your first visit, arrive 10-15 minutes early to sing in. Please bring:

- An insurance card and photo identification
- The COMPLETED paperwork, accurately filled out. If you do not receive the paperwork from us contact us at 410-740-1047or arrive 30 minutes prior to your appointment time to complete the paperwork.
- Copies of any relevant surgical or X-ray reports. They can be faxed to 410-740-2280.

If you have an early morning or an evening appointment, please allow ample time to travel through any congestion that can occur.

Directions:

From Rt. 29 in Howard County, take exit 21B west toward Clarksville. Get into Right lane and drive a few hundred yards to the first signal light at Columbia Rd and turn Right onto Columbia Road. Pass through the signal at Old Annapolis Road, and then turn Right at the light, onto Dorsey Hall Drive. Travel 0.4 miles on Dorsey Hall Drive, to the Dorsey Hall Professional Park on the Left. Turn left into the park and drive to the stop sign. Make another left and look for building number 5024. We are in that building on the first floor.

MCNERNEY & ASSOCIATES PHYSICAL THERAPY

5024 Dorsey Hall Dr, Suite 103, Ellicott City, MD 20142 Phone: 410-740-1047 Fax: 410-740-2280

Returning Patient Insurance Information Update

Name:_____ New Start of care date:_____

Has your health insurance company changed since you were last in? (ie new Medicare coverage) No Yes

If yes New Insurance Company _____

Policy Number _____

Group Number_____

Name of Insure_____

Has your primary care physician changed? YES NO

New Physician_____

Have you used your current physical therapy insurance benefits at another office this year? YES NO

Has your home address changed? YES NO

New Address:_____

_____

Please provide us with phone numbers where we may contact your regarding your scheduled appointments in the event of changes. Also indicate if we may leave a message at each of those numbers.

Okay to leave a message YES NO

Home_____

Work_____

Cell_____

_____ _____

Signature

MCNERNEY & ASSOCIATES PHYSICAL THERAPY

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This form must be fully and accurately **completed before** your appointment. Please fax or bring imaging and surgical reports with you to your first visit.

Patient Information

Name:_____ Date:_____ Date of Birth_____ Age:_____ Height:____ Weight:____

Referred Physician:_____ Referring physician phone#:_____ Date last seen:_____

PCP:_____ PCP Phone#:_____ Date last seen: _____

Occupation:_____ Dominate hand: R L

What problem are you being seen for?_____

Initial Onset/surgery date:_____

My condition is getting: □Better □Worse □Unchanged

On a 0-10 scale (10 being the highest) rate your pain: at rest:_____ at worst:_____ with activity:_____

What makes your pain worse?

What makes your pain better?

What is your chief complaint at this time?

What goals do you have for physical therapy?

Check the box beside each of the symptoms/conditions that pertain to you.

□AIDS or HIV	□Allergies	□Angina/chest pain	□Artificial joint
□Artificial limb, prosthesis	□Balance loss	□Blackout episodes	□Blood pressure High□ Low□
□Brace, splint or support	□Broken bone(s)	□Cancer	□Cane, crutch, walker, wheelchair
□Chemotherapy	□Diabetes	□Dementia	□Dentures, bridge
□Depression	□Dizziness, lightheadiness	□Fainting	□Falls
□Fatigue	□Gastrointestinal disorder	□Headaches, non-migraine	□Heart condition
□Migraine of any type	□Muscle weakness	□Nausea	□Organ transplant
□Parkinson's Disease	□Pelvic floor weakness	□Pregnancy	□Prostate condition
□Radiation treatment	□Reflux/GERD	□RSD/CRPS	□Seizure(s)
□Shortness of breath/COPD	□Sprains	□Stent(s)	□Steroid use, long term
□Stress at work/home	□Tinnitus	□Thyroid, hyper or hypo	□TMJ or Bruxing
□Stroke or TIA	□Vertigo	□Visual Impairment	

Please elaborate on any box(es) you checked above:

Please list any past surgeries:

The information that I have provided on this form is correct to the best of my knowledge. I give consent to McNerney & Associates Physical Therapy to evaluate and treat my condition or the condition of my minor whose information is provided above.

Printed Name:_____ Signature_____ Date:_____

MCNERNEY & ASSOCIATES, P.A.

5024 DORSEY HALL DRIVE ELLICOTT CITY, MD 21042 (410)740-1047 FAX (410) 740-1047

MEDICATION LIST

PATIENT NAME: ______________________________ DATE: ___________________

ARE YOU DIABETIC? YES NO

IF YES CIRCLE ONE: TYPE I TYPE II

HAVE YOU HAD MORE THAN ONE FALL IN THE PAST YEAR? YES NO

DO YOU HAVE BALANCE ISSUES? YES NO

(Include Prescriptions, Over-the-Counter, Vitamins, Supplements, etc.)

MEDICATION	DOSAGE	FREQUENCY	CONDITION REASON FOR TAKING

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Assignment of Insurance Benefits and statement of Financial Responsibility

I hereby authorize and direct any and all insurance carriers providing benefits to me to pay directly to McNerney & Associates Physical Therapy (hereinafter referred to as "the therapists") such sums as may be due and owing them for professional services and for treatment rendered me. I further authorize the therapists to submit a copy of this authorization for payment to any and all insurance carriers which may be responsible for payment of such sums, including but not limited to coverage for Personal Injury Protection (PIP), general medical coverage, Workers Compensation and Medicare.

I fully understand that I am directly and personally responsible to the therapists for all the medical bills submitted by them with regard to treatment rendered. In the event that I directly receive any proceeds of any insurance policy including but not limited to proceeds from any claim under any personal injury protection coverage, commercial insurance or Medicare coverage. I agree to immediately make payments to the therapists upon receipt of such monies. I understand that this authorization and assignment is in no way relieves me of my personal primary obligation to pay for the above stated services and that signing of this form does not prohibit customary billing by the therapists. I further understand that if my insurance coverage produces insufficient funds, I must pay personally for the above stated services, and in the event that there is a deductible or copay charge, it shall be my sole responsibility to pay these charges directly to the therapists. I also understand that any delay in making prompt payment to the therapists of monies received for such services may incur a service charge of 1 ½% per month (18% annual percentage charge) on any unpaid balance more than 90 days delinquent.

Maryland state law requires that insurance companies process any properly submitted claim for payment within 30 days. I understand that if the therapist have not received payment from my insurance company within 60 days on a properly submitted claim, the amount due on the outstanding claim shall immediately be due and payable to the therapists by me personally upon their request.

Further, I agree to make regular co-payments either on the day of treatment or at weekly intervals. Co-payment charges are those that are not covered by insurance policies and may include deductible amounts or payment for supplies. Co-payment is made at the front desk by cash, check or credit card.

I understand that the statute of limitations in the State of Maryland is 3 years from the time services were last performed. In view of this, I hereby agree that the statute with the respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to the therapist by me.

If it should become necessary to turn this account over to collections agency or any attorney for non-payment, I will additionally be responsible for all reasonable court costs, collection fees, and attorney fees. My account will also begin to accrue a service charge of 1 ½% (18% annual percentage) until such time as my account is paid in full. A copy or photocopy of this document shall be binding as an original.

I HAVE CAREFULLY REVIEWED ALL OF THE TERMS AND CONDITIONS OF THE ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF FINANCIAL RESPOSIBILITY, AND I FULLY UNDERSTAND AND AGREE TO BE BOUND BT THIS ASSIGNMENT.

Signature of Patient or Responsible Party_____

Witness_____ Date_____

MCNERNEY & ASSOCIATES, P.A.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

To whom it may concern

YOU ARE HEARBY AUTHORIZED TO GIVE MC NERNEY & ASSOCIATES, P.A. PHYSICAL THERAPISTS, OR ANY REPRESENTATIVE OF THAT OFFICE ANY INFORMATION WHICH MAY BE REQUESTED REGARDING MY CONDITION INCLUDING THE EVALUATINO AND TREATMENT RENDERED BY YOU AND TO ALLOW THEM TO EXAMINE THE FILMS OR ANY IMAGING STUDY PERFORMED BY YOU AND ANY RECORDS OR REPORTS WHICH YOU MAY HAVE REGARDING MY CONDITION OR TREATMENT.

SPECIFICALLY, I GIVE MY PERMISSION FOR THE RELEASE OF:

___ OPERATIVE REPORT(S)_____

___ REPORT(S) OF ARTHROSCOPY_____

___ X-RAY REPORT(S)_____

___MYELOGRAM REPORT(S)_____

___CT SCAN REPORT(S)_____

___MRI REPORT(S)_____

___BONE SCAN REPORT(S)_____

___EMG/NCV REPORT(S)_____

___ BLOOD WORK_____

___0THER_____

_____ _____

PATIENT NAME PRINTED SIGNATURE PATIENT/PARENT OF MINOR

DATE: _____

HIPPA

The Health Information Portability & Accountability Act of 2002 directs that health care providers inform you of your rights regarding disclosure of your personal medical information to other parties. Our office has outlined the types of disclosures, that during your care, may be made available to you and others and your rights regarding these disclosures.

These rights and disclosures are available in a binder for you to review at the front desk and a copy of these may be taken with you upon request.

___I understand my rights about disclosure of my personal medical information. I do not wish to receive a personal copy.

___A copy of the disclosure rights has been made available for me to read. I have received a personal copy.

_____ _____

Printed Name Signature of Patient/Guardian

_____ _____

Date Witness

CANCELLATION/ NO SHOW POLICY

Please understand that missed appointments have an impact on the office as well as other patients. McNerney & Associates, P.A. require 24 hours' notice of cancellation. Cancellations made after the 24 hours may be subject to a $25.00/$50.00 fee. This charge is due from the patient and is not covered under any insurance or flex spending card. If you cancel or no show for three appointments you may be discharged from our care.

_____ _____,

Printed Name Signature/Guardian Signature

PAIN DISABILITY INDEX

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain at is worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

FAMILY/HOME RESPONSIBILITES: This category refers to activities of the home or family. It includes chores, or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school)

0 1 2 3 4 5 6 7 8 8 10

RECREATION: This disability includes hobbies, sports and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

SOCIAL ACTIVITY: This category refers to activities ,which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

0 1 2 3 4 5 6 7 8 9 10

OCCUPATION: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

0 1 2 3 4 5 6 7 8 9 10

SEXUALITY BEHAVIOR: This category refers to the frequency and quality of one's sex life.'

0 1 2 3 4 5 6 7 8 9 10

SELF CARE: This category includes activities, which involve personal maintenance and independent daily living (i.e. taking a shower, driving, getting dressed, etc)

0 1 2 3 4 5 6 7 8 9 10

LIFE SUPPORT ACTIVIES: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Signature:_____ Please Print:_____

Date:_____