McNerney & Associates, P.A.
PHYSICAL THERAPISTS

5024 Dorsey Hall Drive
Suite 103
Ellicott City, MD 21042
PH 410-740-1047
FX 410-740-2280
www.vm-pt.com

Thank you for choosing McNerney & 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 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 your insurance plan or decide if you wish to be treated out of network. We are participating providers with Medicare, All Carefirst products, Aetna, Cigna, Allegiance, EHP, PHCS, 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 to get the days and times most convenient for you. We typically have our schedules open 6 weeks out. Initial appointments are one hour and follow up appointments are 45 minutes.

If you need to cancel your 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 the cancellation policy may result in a fee:

-$25.00 for follow up missed appointment less than 24 hour notice

-$50.00 for initial appointment missed or canceled less than 24 hour notice

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

COMPLETED PACKET OF PAPERWORK
Insurance card and photo ID
Copies of any relevant surgical, or x-ray, MRI reports

If you do not receive the paperwork from the website or via email, please contact our office at 410-740-1047 or arrive 30 minutes prior to your appointment to complete paperwork.

If you have an early morning or evening appointment, please allow ample time for travel through 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 Rd. Pass through signal at Old Annapolis Road, and then turn Right 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 left and look for building number 5024. WELCOME.

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Initial/Return Visit
Patient Information

Name:_____ DOB:_____

Address:_____

_____

Phone: Cell:_____ Home:_____ Work:_____

Email:_____HT:_____ WT:_____ Shoe Size:_____

Emergency Contact:_____ Emergency Phone:_____

Referring Physician:_____ Phone:_____

Condition to be treated:_____ Date of Onset:_____

_____

Primary Ins. Name:_____ Secondary Ins. Name:_____

Primary Ins. ID#_____ Group:_____

Secondary Ins. ID#_____ Group:_____

Name of Insured: _____Insured Date of Birth:_____

Insured Employer:_____ Phone:_____

Employer Address:_____

This information is true and correct to the best of my knowledge. I give my permission for evaluation and treatment to be rendered by McNerney & Associates, P.A. Physical Therapy and understand that I am personally responsible for any unpaid balances not covered by my insurance.

_____ _____ _____

Print Name of Signee Signature of Responsible Party Date

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

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 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 by 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 services were last performed. In view of this, I hereby agree that the statute with the respect to any claim or fees for services mentioned above with 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 collection agency for 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 RESPONSIBILITY, AND I FULLY UNDERSTAND AND AGREE TO BE BOUND BY THIS ASSIGNMENT

Signature of Patient or Responsible Party_____

Witness_____ Date _____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

To whom it may concern

YOU ARE HEREBY AUTHORIZED TO GIVE MCNERNEY & ASSOCIATES, P.A PHYSICAL THERAPISTS, OR AN REPRESENTATIVE OF THAT OFFICE ANY INFORMATION WHICH MAY BE REQUESTED REGARDING MY CONDITION INCLUDING THE EVALUATION 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_____

___OTHER_____

Patient Name Printed: _____

Signature Patient/Parent of minor: _____

DATE: _____

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HIPPA & Cancellation Policy

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, 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 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 out care.

Printed Name	Signature/Guardian Signature

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This form must be fully and accurately completed before you may be seen by the physical therapist. Please fax or bring imaging and surgical reports with you to your first visit.

Patient Information

Name: _____ Date of First Visit: _____ Date of Birth: _____ Age: _____

Referred by: _____ PCP: _____ Date last seen by PCP: _____

Occupation: _____ Leisure Activity: _____ Dominant Hand: R or L

Condition for which you seek treatment: _____

Initial Onset Date: _____ Date of Recent Flare up: _____

My condition is:

❑ Getting Better ❑ Getting Worse ❑ Not Changing

On a 0-10 scale (10 being the highest) rate your pain: at rest_____ at worst_____ with activity_____

List all traumatic injuries you can recall even if they do not appear to relate to the condition for which you are seeking treatment.

Indicate each of the symptoms or conditions that pertain to you. In addition, please elaborate your symptoms/conditions.

- ❑ AIDS or HIV
- ❑ Allergies
- ❑ Angina or Chest Pain
- ❑ Artificial Joint
- ❑ Artificial Limb, Prosthesis
- ❑ Balance Loss, or Disequilibrium
- ❑ Blackout Episodes
- ❑ Blood Pressure
  - ❑ Low
  - ❑ High
- ❑ Brace, Splint or Support
- ❑ Broken bone(s)
- ❑ Cancer
- ❑ Cane, crutch, walker, wheelchair
- ❑ Diabetes
- ❑ Dementia
- ❑ Dentures, bridge
- ❑ Depression
- ❑ Dizziness, lightheadedness
- ❑ 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 at 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 corrected to the best of my knowledge, I give consent to McNerney and Associates, P.A. to evaluate and treatment my condition or the condition of my minor-age child whose information is provided above.

_____ _____ _____

Printed Name Signature Date

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Medication List

Print Name: _____ Date: _____

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

MEDICATION	DOSAGE	FREQUENCE	CONDITION (reason for taking medication)

Are you diabetic? Please Circle **YES** or **NO**

If YES, Circle **Type I** or **Type II**

Have you had more than one fall in the past year? Please Circle **YES** or **NO**

Do you have balance issues? Please Circle **YES** or **NO**

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Geriatric Depression Scale

Instructions: Choose the best answer for how you felt over the past week

1. Are you basically satisfied the your life? ___YES ___**NO**

2. Have you dropped many of your activities and interests? ___**YES** ___NO

3. Do you feel that your life is empty? ___**YES** ___NO

4. Do you often get bored? ___**YES** ___NO

5. Are you in good spirits most of the time? ___YES ___**NO**

6. Are you afraid that something bad is going to happen to you? ___**YES** ___NO

7. Do you feel happy most of the time? ___YES ___**NO**

8. Do you often feel helpless? ___**YES** ___NO

9. Do you prefer to stay home, rather than going out and doing new things? ___**YES** ___NO

10. Do you feel you have more problems with memory than most? ___**YES** ___NO

11. DO you think it is wonderful to be alive now? ___YES ___**NO**

12.Do you feel pretty worthless the way you are now? ___**YES** ___NO

13. Do you feel full of energy? ___YES ___**NO**

14. Do you feel that your situation is hopeless? ___**YES** ___NO

15. Do you think most people are better off than you are? ___**YES** ___NO

SCORING MEANING:
ANSWERS IN **BOLD** INDICATE DEPRESSION. SCORE1 POINT FOR EACH BOLDED ANSWER.
SCORE ABOVE 5 SUGGESTIVE OF DEPRESSION/ WARRANT A FOLLOW UP COMP. ASSESSMENT.
SCORE GREATER THAN 10 IS ALMOST ALWAYS INDICATIVE OF DEPRESSION

ELDER ABUSE SUSPICION INDEX (EASI)

QUESTIONS 1-5 ASKED OF PATIENT
QUESTION 6 BY PROVIDER
WITHIN THE LAST 12 MONTS:

1. HAVE YOU RELIED ON PEOPLE FOR ANY OF THE FOLLOWING: BATHING, DRESSING, SHOPPING, BANKING OR MEALS? _____YES _____NO

2. HAS ANYONE PREVENTED YOU FROM GETTING FOOD, CLOTHES, MEDICATION, GLASSES, HEARING AIDES, OR MEDICAL CARE, OR FROM BEING WITH PEOPLE YOU WANT TO BE WITH? _____YES _____NO

3. HAVE YOU BEEN UPSET BECAUSE SOMEONE TALKED TO YOU IN A WAY THAT MADE YOU FEEL SHAMED OR THREATENED? _____YES _____NO

4. HAS ANYONE TRIED TO FORCE YOU TO SIGN PAPERS OR TO USE MONEY AGAINST YOUR WILL? _____YES _____NO

5. HAS ANYONE MADE YOU AFRAID, TOUCHED YOU IN WAYS THAT YOU DID NOT WANT OR HURT YOU PHYSICALLY? _____YES _____NO

PROVIDER

6. ELDER ABUSE **MAY** BE ASSOCIATED WITH FINDINGS SUCH AS: POOR EYE CONTACT, WITHDRAWN NATURE, UNDERNOURISHMENT, HYGIENE ISSUES, CUTS, BRUISES, INAPPROPRIATE CLOTHING, OR MEDICATION COMPLIANCE ISSUES. DID YOU NOTICE ANY OF THESE TODAY OR IN THE LAST 12 MONTHS? _____YE _____NO