Parkinson's and Movement Disorders Center of Maryland

Affiliated with the Morris K. Udall Parkinson's Disease Research Center at Johns Hopkins University

Stephen E. Grill, M.D., Ph.D.

8180 Lark Brown Road
Suite 101
Elkridge, MD 21075

Phone: (443) 755-0030
Fax: (443) 755-0031

On behalf of the Parkinson's & Movement Disorders Center of Maryland, I would like to welcome you to our office! The following check list is to help you prepare your Registration Packet in complete detail, ensuring we have the pertinent information needed to provide you the most accurate quality of care.

THE ATTACHED FORMS MUST BE COMPLETED AND RETURNED TO US BEFORE YOUR APPOINTMENT WILL BE SCHEDULED!

___ Each page of the Registration including (health history, social, family, current medication, allergies, and your symptoms) are completed

___ Insurance information is complete with Member ID #, Group # and any copay

___ Your Primary Care Doctor and Referring Doctor information has all the names, address, phone, and fax numbers listed

___ Both the HIPPA and the Financial Policies forms are signed and dated

___ The Medical Records Release Form is completed with your signature and full name of doctor/lab/hospital/facility, along with their address, phone and fax numbers of each

Please contact us if you have any questions while filling out this Registration Packet.

Please bring your current insurance cards and a valid photo ID to *every* visit!

Each patient is responsible for obtaining a valid referral, *if* your insurance requires you to have one to see a specialist – so please check with your insurance carrier!

Be sure to wear comfortable clothing & shoes and bring reading glasses, hearing aids, along with any walking assistance you regularly use such as a cane, walker or wheelchair to each visit.

Once registration forms are completely filled out, sent back to us and reviewed, you then will be contacted to schedule your first appointment.

Thank You

Parkinson's and Movement Disorders Center of Maryland

REGISTRATION FORM

(Please Print Clearly in Blue or Black Ink)

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email Address:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security #:		Home Phone #: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation: ❑FT ❑PT ❑Retired ❑Student	Employer **(or previous employer, if retired)**:		Employer Phone #: ( )	Cell Phone #: ( )		
Referring Physician (first and last name):	Dr.					
Street address:		Office Phone #: ( )		Office Fax #: ( )		
P.O. box:	City:		State:	ZIP Code:		

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Please indicate **primary** insurance	❑ Aetna	❑ Blue Cross Blue Shield	❑ Kaiser Permanente	❑ Mamsi/MDIPA/Optimum Choice	
❑ Medicare	❑ United Healthcare	❑ Self Pay	❑ Other (specify)		
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Policy/ID #:	Group #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of **secondary** insurance (if applicable):	Subscriber's name:		Policy/ID #:	Group #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Parkinson's and Movement Disorders Center of Maryland. I understand that I am financially responsible for any balance. I also authorize Parkinson's and Movement Disorders Center of Maryland to release any information, including medical information required to process my claims.

Patient/Guardian signature *Date*

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
(Please Print Clearly in Blue or Black Ink)

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Internist/Family Physician (first & last name):	Dr.	**Date of Last Physical Exam:**

Internist/Family Physician Street Address:	**Office Phone #:** ( )	**Office Fax #:** ( )

P.O. Box:	**City:**	**State:**	**ZIP Code:**

Reason for Visit: ☐ Parkinson's Disease ☐ Dystonia ☐ RLS ☐ Other (Please specify):

PERSONAL HEALTH HISTORY

Medical Problems Other Doctors Have Diagnosed		
Year	Diagnosis	Doctor
Surgeries		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Medication Name	Strength	Times Taken
Allergies to medications		
Medication Name	Reaction You Had	

-Please Turn Over-

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
Tobacco	Do you use or have you ever used tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	DECEASED		AGE	SIGNIFICANT HEALTH PROBLEMS	DECEASED
Mother			☐ Y ☐ N	**Father**			☐ Y ☐ N
Sibling ☐ M ☐ F			☐ Y ☐ N	**Children** ☐ M ☐ F			☐ Y ☐ N
☐ M ☐ F			☐ Y ☐ N	☐ M ☐ F			☐ Y ☐ N
☐ M ☐ F			☐ Y ☐ N	☐ M ☐ F			☐ Y ☐ N
☐ M ☐ F			☐ Y ☐ N	☐ M ☐ F			☐ Y ☐ N

PERSONAL MEDICAL HISTORY

Check if you have, or have had, any of the following medical conditions.

☐ Decreased Hearing	☐ Chest Pain	☐ Moodiness	☐ Heart Palpitations
☐ Ringing in Ear	☐ Diarrhea	☐ Nervousness	☐ Irregular Pulse
☐ Dizziness	☐ Constipation	☐ Sleep Problems	☐ Swollen Ankles
☐ Lightheadedness	☐ Trouble Swallowing	☐ Depression	☐ Tingling Sensations
☐ Fainting	☐ Slurred Speech	☐ Numbness	☐ Discoordination
☐ Blurred Vision	☐ Weakness	☐ Falls	☐ Double Vision
☐ Back or Leg Pain	☐ Tremors	☐ Stiffness	☐ Impaired Smell
☐ Slowed Movement	☐ Trouble Finding Words	☐ Poor Appetite	☐ Nose Bleeds
☐ Shuffling Walking	☐ Poor Comprehension	☐ Weight Loss – Recent	☐ Impaired Taste
☐ Shortness of Breath	☐ Memory Loss	☐ Chronic Fatigue	☐ Loss of Urination
☐ Heart Disease	☐ Diabetes	☐ Cataracts	☐ Glaucoma
☐ Pneumonia	☐ Cancer	☐ Lyme Disease	☐ Asthma/COPD
☐ Urinary Infections	☐ High Blood Pressure	☐ Seizures	

WOMEN ONLY

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian signature *Date*

Parkinson's & Movement Disorders Center of Maryland
USE AND DISCLOSER OF PROTECTED HEALTH INFORMATION

Section I – Patient Acknowledgement & Consent Form

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Parkinson's and Movement Disorders Center of Maryland, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date.

You have the right to request restrictions on how your protected health information may be used or disclose for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge notification of Privacy Practices.

X	**X**
Patient/Guardian signature	*Date*
X	
Print Full Name	

Section II – Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and research. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or that you are being referred to for treatment.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Record Access: Our entire staff is allowed full access to patient information in order to ensure the proper provision of treatment.

Research: We may use de-identified data for research purposes only. If you object, please inform your physician.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the healthy or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, and/or letters).

X	**X**
Patient/Guardian signature	*Date*
X	
Print Full Name	

Continue...

Section III – Personal Representative or Family Authorized Access to Health Information

Name or specifically identify persons other than medical professionals you authorize disclosure to of your Protected Healthcare Information regarding treatment, payment, and other healthcare operations.

Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*

Section IV – Authorization for Use of Answering Machine/Voice Mail

PDMD Center physicians and staff are routinely unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, and appointment confirmation and instructions.

x _____ (initial) Yes, I agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work, and cell phone.

x _____ (initial) Yes, I agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on the following devices: (Please initial next to the applicable communication device.)

_____ Home Phone _____ Work Phone _____ Cell Phone

x _____ (initial) No, I do not agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on my home, work, and/or cell phone. (Confirmation calls will not be provided to patients that do not allow messages to be left.)

x _____ **x** _____

Patient/Guardian signature *Date*

x _____

Print Full Name

For Internal Office Use Only

☐ Consent received by _____ Date _____

☐ Consent refused by patient and treatment refused as permitted.

Parkinson's and Movement Disorders Center of Maryland

FINANCIAL AND OFFICE POLICIES

PAYMENT OF MEDICAL BILLS

Our policy is payment must be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 90 days of treatment. If payment is not received within 90 days of treatment, your account may be referred to collections and appointments will be cancelled until the balance is paid in full. Payment is accepted in the form of cash, check, or credit card. If payment is made by check and the check is returned, there will be a returned check fee of $25.00 charged to your account.

REFERRALS

Referrals are the patient's responsibility. Our office must have a valid referral from the primary care physician's office on file before the patient's appointment. Patients are given the following two options if a valid referral is not on file:

1. Pay for the appointment in full. Cash, checks, Money Orders, and all major credit cards except American Express are accepted.
2. Reschedule the appointment after a valid referral is obtained.

Referrals may be considered invalid if:

- the referral is not from the primary care physician
- the referral is not signed
- there is not start and/or expiration date on the referral
- the referral is not legible
- the expiration date has passed
- the number of visits allowed have been used
- any alterations have been made on the referral not by the primary care office

CO-PAYS

Co-pays are due at the time services are rendered. Cash, checks, Money Orders, and all major credit cards except American Express are accepted.

CHANGE OF INSURANCE

Patients that have a change of insurance but do not inform us of the change prior to the services being rendered will accept responsibility for payment for these services. Our office does not submit claims to insurances received after date of service.

Patients that receive Botox, Myobloc, Dysport or Xeomin injections must inform us as soon as a change in insurance has been made. Prior authorizations of these services may take up to 90 days. Patients that do not inform us prior to their scheduled appointment will not be injected. If a patient informs us after an injection has been preformed, the balance becomes the patient's responsibility.

ACCEPTED INSURANCE

Due to the numerous insurance companies and plans, our office asks patients to call their insurance companies and verify their doctor is a participating provider within their plan. Any balances accrued due to our physicians not being participating providers, will be the responsibility of the patient.

Continue...

CLAIM SUBMISSION

As a courtesy to our patients, we will submit claims to primary and secondary insurances only. We will provide any information needed for patients to submit their own claims to third insurances.

APPOINTMENTS

As a courtesy to our patients, our office currently uses a telephone service that provides confirmation calls to all patients 48 hours prior to the appointment date. Due to our doctors' full schedules, we require 48 hours notice for non-emergency cancellations. No call-No Shows and cancellations made less than 48 hours prior to the appointment date for non-emergency reasons will be subject to the following fees:

$25.00 Follow up and BOTOX appointments

$40.00 New patient and DBS appointments.

PAPERWORK

Disability paperwork that must be completed by the physician has a fee of $10.00/per page. Payment is expected within 30 days or by the next date of service, which ever occurs first.

MVA paperwork that must be completed by the physician has a flat fee of $25.00. Payment is expected within 30 days or by the next date of service, which ever occurs first.

RECORDS

Records are available for pick up or to be sent for the following fees plus any postage fees needed to send the records (except to physicians):

$22.18 Retrieval Fee

$0.73 Per Page

Payment is expected within 30 days or by the next date of service, which ever occurs first.

PRESCRIPTION REFILLS

Our office has 48 hour turn-around period for all prescription refills. Our office mails and/or faxes prescriptions to mail order pharmacies when patients provide all information needed for the company to process the order.

INJECTIONS

Toxin injections are not able to be preformed on a first visit evaluation due insurance companies and our office requiring prior authorizations, which may take up to 90 days to process. In order for our office to submit claims including injections to insurance companies, prior authorizations must be obtained prior to injections.

Patients who have not been injected and/or do not have a scheduled appointment within six months of the last injection will have to start the prior authorization process again and toxin will have to be reordered.

ACCEPTANCE OF POLICIES

I have read, understand, and will abide by all the policies enforced by the Parkinson's & Movement Disorders Center of Maryland.

I agree to pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges accrued, including any collections fees.

Patient/Guardian signature *Date*

PARKINSON'S & MOVEMENT DISORDER CENTER OF MD
Stephen Grill, M.D., Ph.D.
8180 Lark Brown Rd. Suite 101, Elkridge, MD 21075 Phone: (443)755-0030 Fax: (443)755-0031

Movement Questionnaire

Name: _____ Date: ____/____/____

1. Is there any intellectual impairment?
□ 0 – none
□ 1 – Mild. Consistent forgetfulness with partial recollection of events and no other difficulties.
□ 2 – Moderate memory loss with disorientation and moderate difficulty handling complex problems. Mild but definite impairment at home with occasional need for prompting by caregiver.
□ 3 – Severe memory loss with disorientation for time and often to place. Severe impairment in handling problems.
□ 4 – Severe memory loss with orientation preserved to person only. Unable to make judgments or solve problems. Requires much help in personal care. Cannot be left alone at all.

2. Is there any "thought disorder"?
□ 0 – none
□ 1 – Vivid dreaming where the patient has difficulty distinguishing dreaming from reality.
□ 2 – "Benign" hallucinations with insight retained
□ 3 – Occasional to frequent hallucinations or delusions without insight. It could interfere with daily activities.
□ 4 – Persistent hallucinations, delusions or florid psychosis. Not able to care for self.

3. Is there any depression?
□ 0 – none
□ 1 – Periods of sadness or guilt greater than normal; never sustained for days/weeks
□ 2 – Sustained depression (1 week or more). No significant problems with sleep, appetite, or loss of interest
□ 3 – Sustained depression with problems with sleep, appetite or loss of interest.
□ 4 – Sustained depression with problems with sleep, appetite, or loss of interest as well as suicidal thoughts.

4. Motivation/Initiative
□ 0 – normal
□ 1 – Less assertive than usual; more passive
□ 2 – Loss of initiative or disinterest in elective (non-routine) activities
□ 3 – Loss of initiative or disinterest in day to day (routine) activities
□ 4 – Withdrawn; complete loss of motivation

5. Is there impairment of speech?
□ 0 – none
□ 1 – Mildly affected; no difficulty being understood
□ 2 – Moderately affected; sometimes asked to repeat statements
□ 3 – Severely affected; frequently asked to repeat statements
□ 4 – Unintelligible most of the time

6. Is there excessive salivation?
□ 0 – No excess salivation
□ 1 – Slight but definite excess saliva in mouth; may have nighttime drooling
□ 2 – Moderately excessive saliva; may have minimal drooling during the day
□ 3 – Marked excess of saliva with some drooling
□ 4 – Marked drooling; requires constant tissue or handkerchief

7. Are there problems with swallowing?
□ 0 – Normal swallowing
□ 1 – Rare choking. Coughs when eating
□ 2 – Occasional choking
□ 3 – Requires soft food
□ 4 – Requires feeding tube

8. Handwriting
□ 0 – Normal
□ 1 – Slightly slow or small
□ 2 – Moderately slow or small; all words legible
□ 3 – Severely affected; not all words legible
□ 4 – The majority of words are not legible

9. Cutting food and handling utensils
□ 0 – Normal
□ 1 – Somewhat slow and clumsy but no help needed
□ 2 – Can cut most foods, although clumsy and slow; some help needed
□ 3 – Food must be cut by someone; can still feed self slowly
□ 4 – Needs to be fed

PLEASE TURN OVER TO FINISH

10. Dressing
□ 0 – Normal
□ 1 – Somewhat slow but no help needed
□ 2 – Occasional assistance with buttoning or getting arms in sleeves needed.
□ 3 – Considerable help required but can do some things alone
□ 4 – Requires total assistance with dressing

11. Hygiene
□ 0 – Normal
□ 1 – Somewhat slow but no help needed
□ 2 – Needs help showering/bathing or very slow in hygienic care
□ 3 – Requires assistance for washing, brushing teeth, combing hair and going to bathroom
□ 4 – Uses catheter or other mechanical aids

12. Turning in bed and adjusting bed clothes
□ 0 – Normal
□ 1 – Somewhat slow and clumsy but no help needed
□ 2 – Can turn alone or adjust sheets, but with great difficulty
□ 3 – Can initiate but not turn or adjust sheets alone
□ 4 – Needs total assistance

13. Falling (unrelated to phenomenon of "freezing" in which feet cannot be lifted off floor
□ 0 – None
□ 1 – Rare falling
□ 2 – Occasionally falls, less than once per day
□ 3 – Falls an average of once daily
□ 4 – Falls more than once daily

14. Freezing when walking
□ 0 – None
□ 1 – Rare freezing when walking; may hesitate when starting to walk
□ 2 – Occasional freezing when walking
□ 3 – Frequent freezing when walking. Occasionally falls because of freezing
□ 4 – Frequent falls from freezing

15. Walking
□ 0 Normal
□ 1 – Mild difficulty. May not swing arms or may tend to drag leg
□ 2 – Moderate difficulty but requires little or no assistance
□ 3 – Severe disturbance of walking requiring assistance
□ 4 – Cannot walk at all even with assistance

16. Tremor
□ 0 – Absent
□ 1 – Slight and infrequently present
□ 2 – Moderate and bothersome
□ 3 – Severe; interferes with many activities
□ 4 – Marked; interferes with most activities

17. Sensory complaints related to Parkinson's Disease (Not related to other disorders)
□ 0 – None
□ 1 – Occasionally has numbness, tingling or mild aching
□ 2 – Frequently has numbness, tingling or aching; not distressing
□ 3 – Frequent painful sensation
□ 4 – Excruciating pain

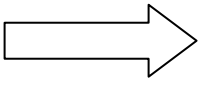
Are there times when dyskinesias are present?
□ No □ Yes
Are there times when the Parkinson's medications don't work?
□ No □ Yes
Is there loss of appetite, nausea or vomiting?
□ No □ Yes
Are there sleep disturbances?
□ No □ Yes
Are there feelings of lightheadedness when standing?
□ No □ Yes

Daytime Sleepiness Questions

Please rate your chances of falling asleep or dozing in the following situations:

Situation	Never	Slight	Moderate	High
Sitting and reading				
Watching television				
Sitting inactive in a public place (movie or meeting)				
As a passenger in a car for an hour (without a break)				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch				
Driving a car stopped in traffic				

Assistive Devices:
□ None □ Walker without wheels □ Wheelchair
□ Straight cane □ Walker with wheels □ Commode
□ Quad cane □ Rollator walker



FINISHED

Parkinson's & Movement Disorder Center of Maryland
8180 Lark Brown Road, Suite 101 Elkridge, Maryland 21075
Phone: (443)755-0030 Fax: (443)755-0031

Cervical Dystonia Questionnaire

Name:_____ Date: _____

1. Severity of Pain
Rate the severity of neck pain during the last week, on a scale of 0-10, where a score of 1 represents a minimal ache and 10 represents the most excruciating pain imaginable.

Worst	0 1 2 3 4 5 6 7 8 9 10
Average	0 1 2 3 4 5 6 7 8 9 10
Least	0 1 2 3 4 5 6 7 8 9 10

2. Duration of Pain (rate the duration of neck pain)
[] 0- None
[] 1- Present < 10% of the time
[] 2- Present 10- <25% of the time
[] 3- Present 25-< 50% of the time
[] 4- Present 50- <75% of the time
[] 5- Present > 75% of the time

3. Disability Due to Pain (the degree to which pain contributes to disability)
[] 0- No limitation or interference from pain
[] 1- Pain is quite bothersome, but not a source of disability
[] 2- Pain definitely interferes with some tasks, but in not a major contributor to disability
[] 3- Pain accounts for some (less than half) but not all disability
[] 4- Pain is a major source of difficulty with activities; separate from this, head pulling is also a source of some (less than half) disability
[] 5- Pain is a major source of disability; without it, most impaired activities could be performed quite satisfactorily despite the head pulling.

4. Work (occupation or housework/home management)
[] 0- No difficulty
[] 1- Normal work expectations with satisfactory performance at usual level of occupation, but some interference by cervical dystonia
[] 2- Most activities unlimited; selected activities very difficult and hampered, but still possible with satisfactory performance
[] 3- Working at lower than usual occupational level; most activities hampered; all possible but less than satisfactory performance in some activities
[] 4- Unable to engage in voluntary or gainful employment; still able to perform some domestic responsibilities satisfactorily
[] 5- Marginal or no ability to perform domestic responsibilities

5. Activities of Daily Living (ex. eating, dressing, hygiene Including washing, shaving, and applying make-up)
[] 0- No difficulty with any activity
[] 1- Activities unlimited, but some interference by cervical dystonia
[] 2- Most activities unlimited; selected activities very difficult and hampered, but still possible using simple tricks
[] 3- Most activities hampered or laborious but still possible; may use extreme tricks
[] 4- All activities impaired; some impossible or require assistance
[] 5- Dependent on others in most self-care tasks

6. Driving
[] 0- No difficulty (or has never driven a car)
[] 1- Unlimited ability to drive, but bothered by torticollis
[] 2- Unlimited ability to drive, but requires tricks (including touching or holding face, holding head against headrest) to control cervical dystonia
[] 3- Can drive only short distances
[] 4- Usually cannot drive because of cervical dystonia
[] 5- Unable to drive and cannot ride in a car for long stretches as a passenger because of cervical dystonia

7. Reading
[] 0- No difficulty
[] 1- Unlimited ability to read in normal seated position, but bothered by cervical dystonia
[] 2- Unlimited ability to read in normal seated position, but requires use of tricks to control cervical dystonia
[] 3- Unlimited ability to read, but requires extensive measures to control cervical dystonia or only able to read in non-seated position (ex. lying down)
[] 4- Limited ability to read because of cervical dystonia despite use of tricks
[] 5- Unable to read more than a few sentences because of cervical dystonia

8. Television
[] 0- No difficulty
[] 1- Unlimited ability to watch television in normal seated position but bothered by cervical dystonia
[] 2- Unlimited ability to watch television in normal seated position but requires use of tricks to control cervical dystonia
[] 3- Unlimited ability to watch television, but requires extensive measures to control cervical dystonia or only able to watch in non-seated position
[] 4- Limited ability to watch television because of cervical dystonia. Unable to watch television for more than a few minutes because of cervical dystonia
[] 5- Unable to watch television more than a few minutes because of cervical dystonia

9. Activities Outside the Home
[] 0- No difficulty
[] 1- Unlimited activities but bothered by cervical dystonia
[] 2- Unlimited activities, but requires use of simple tricks to accomplish them
[] 3- Only accomplishes activities when accompanied by others because of cervical dystonia
[] 4- Limited activities outside the home; certain activities impossible or given up due to cervical dystonia
[] 5- Rarely, if ever, engages in activities outside the home

Parkinson's and Movement Disorders Center of Maryland

Affiliated with the Morris K. Udall Parkinson's Disease Research Center of Excellence at Johns Hopkins University
Stephen Grill, M.D., Ph.D.

8180 Lark Brown Road, Suite 101 Elkridge, Maryland 21075
Phone: 443-755-0030
Fax: 443-755-0031

Authorization for Release of Medical Records

Patient Information:	*Request Release from:*
Name: _____	**Doctor:** _____
DOB: _____	**Address:** _____
Address: _____	_____
_____	**Phone#:** _____
Phone#: _____ _____	**Fax #:** _____

I hereby authorize you to release a copy of my medical records to Parkinson's and Movement Disorders Center of Maryland that will be used for continuation of my medical care. I reserve the right to revoke this authorization in writing at anytime. I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

_____ _____
Patient or Guardian Signature Date

Please include the following items:

_____ Admission notes
_____ Discharge summary
_____ Operative reports
_____ EKG's
_____ X-ray reports
_____ Injection notes
_____ Progress notes
_____ Pathology reports
_____ Consultations notes
_____ Laboratory tests
_____ Stress tests
_____ Other _____

Remarks: _____

This authorization will expire on: _____.

PARKINSON'S & MOVEMENT DISORDERS CENTER OF MARYLAND
Affiliated with the Morris K. Udall Parkinson's Disease Research Center of Excellence at Johns Hopkins University
Stephen E. Grill, M.D., Ph.D.

8180 Lark Brown Road, Suite 101
Elkridge, Maryland 21075
www.pdmdcenter.com

Phone: 443-755-0030
Fax: 443-755-0031

Directions to Our Office

From I-95 North or South:

Take MD-175 exit 41B toward Jessup/Columbia. Merge onto MD-175 West/Waterloo Road via exit 41B toward Columbia. After going approximately ½ mile, turn right onto MD-108 Waterloo Road. At the second traffic light, turn right onto Lark Brown Road. Make a left at the next signal light into our office complex. After you turn into the office complex, make an immediate left and our office will be on the right, suite 101.

From US 29 North or South:

Merge onto MD-175 East/Patuxent Parkway via exit 20A toward Jessup. After going approximately 4 miles, turn left onto MD-108 Waterloo Road. At the second traffic light, turn right onto Lark Brown Road. Make the first left into the office complex. After you turn into the office complex, make an immediate left and go around to the back of the building. Our office is suite# 101.

From Route 70 East or West:

Merge onto US 29 South/Columbia Pike via exit 87A toward Columbia/Washington. After traveling approximately 3 miles, merge onto MD-100 east via exit 22 on the LEFT towards Glen Burnie. Travel approximately 3.5 miles and merge onto Snowden River Parkway via exit 2. At the first traffic light, turn left onto MD-108 Waterloo Road. Approximately 1.5 miles, turn left onto Lark Brown Road. Make the second left into the office complex. After you turn into the office complex, make an immediate left and go around to the back of the building. Our office is suite# 101.