

**PLEASE STOP AT THE
REGISTRATION DESK ON
THE FOURTH FLOOR PRIOR
TO APPOINTMENT**

CARDIOLOGY

Francis P. Day, M.D.
John P. Fisher, M.D.
Leslie H. Poor, M.D.
Sean C. Curran, M.D.
Sheetal Chandhok, M.D.
Tarun Mathur, M.D.
Laura S. Immordino, M.D.
(610) 525-1202
Glenn R. Harper, M.D.
John C. Steers, Jr., M.D.
Lawrence S. Mendelson, M.D.
Howard B. Kramer, M.D.
Sarang S. Mangalmurti, M.D.
(610) 527-1165
Jason T. Bradley, M.D.
Jeffrey A. Wuhl, M.D.
(484) 380-2808



825 OLD LANCASTER ROAD SUITE 440
BRYN MAWR, PA 19010
Phone: 610-525-4511
Fax: 610-525-8561

DERMATOLOGY

Rochelle R. Weiss, M.D.
Daniel B. Roling, M.D.
Danielle M. DeHoratius, M.D.
Matthew E. Halpern, M.D.
Caroline M. MacFarlane, M.D.
Michael D. Gober, M.D.
(610) 642-1090

ENDOCRINOLOGY

Cheryl A. Koch, M.D.
Vanita P. Treat, M.D.
Denise Joffe, M.D.
Margaret T. Ryan, M.D.
(610) 527-1604

GASTROENTEROLOGY

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Robert R. Atkins, M.D.
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Jeffrey N. Retig, M.D.
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Thomas J. McKenna, M.D.
Michelle C. Springer, D.O.
Rita L. Ritsema, M.D.
(610) 525-9570

HEMATOLOGY-ONCOLOGY

Sandra F. Schnell, M.D.
John G. Devlin, M.D.
Sameer Gupta, M.D., MPH
Molly S. Stumacher, M.D.
(610) 525-4511

INFECTIOUS DISEASE

Peter G. Spitzer, M.D.
Bartholomew R. Bono, M.D.
Luciano Kapelusznik, M.D.
Young S. Kim, M.D.
(610) 527-8118

NEUROLOGY

Richard A. Eisner, M.D.
Christopher J. Reid, M.D.
George J. Hart, M.D.
Pragati Shukla, M.D.
Laurence D. Fine, M.D.
(610) 527-8140

PULMONARY/CRITICAL CARE

David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Catherine A. Riley, M.D.
(610) 527-4896

RHEUMATOLOGY

Donald S. Miller, M.D.
Kendra K. Zuckerman, M.D.
Pierre Minerva, M.D.
Stephanie D. Flagg, M.D., Ph.D.
Liliane Min, M.D.
Belinda K. Birnbaum, M.D.
(610) 525-4463

NOTICE TO ALL HEMATOLOGY/ONCOLOGY PATIENTS

Payment for **ALL** treatments is expected at the time of service.

This includes balances due from **all high deductible** health insurance plans and/or plans that require **co-insurance**.

Payment may be made by check or credit card.

We appreciate your understanding and cooperation with this policy.

The Hematology/Oncology Department

DIRECTIONS

From 476 N:

Take 476 N to exit 13 (Villanova/St. Davids)

Make right on to Route #30 East

Follow Route 30 for approximately 1.7 miles

When you reach McDonald's (on left), make a right on to County Line Road

Continue on County Line Road to Bryn Mawr Avenue, make a left on to Bryn Mawr Avenue

Follow Bryn Mawr Avenue to the first traffic light (Old Lancaster Road), turn left on to Old Lancaster Road

Bryn Mawr Medical Specialists (825 Old Lancaster Road) is on the right (Medical Arts Pavilion)

Parking may be found in the parking garage across the street or with valet parking

From 476 S:

Take 476 S to exit 13 (Villanova/St. Davids)

Make a right on to Route 30 East

Follow directions above

From 76 E and W to 476 N and S follow directions above

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Fax: 610-525-8561

The Hematology-Oncology team at Bryn Mawr Medical Specialists (BMMSA) is comprised of physicians who are board certified in Oncology, Hematology and Internal Medicine, oncology nurse specialists, lab and support staff. Our physicians care for patients with hematologic (blood) or oncologic (cancer) conditions. When necessary, our physicians admit patients to Bryn Mawr Hospital.

The Bryn Mawr Hospital and our practice provide a complete range of hematology and oncology services with a very "patient-oriented" philosophy.

Sandra F. Schnell, M.D. is a graduate of Tufts University and Jefferson Medical College. She completed a fellowship in both Hematology and Oncology at the Yale University Cancer Center in 1986 and most recently was an Associate Professor at Temple Cancer Center before coming to BMMSA in 1998.

John G. Devlin, M.D. is a graduate of St. Joseph's University and Temple University School of Medicine. He completed his residency in Internal Medicine as well as a fellowship in both Hematology and Oncology at Temple University Hospital and Fox Chase Cancer Center. He joined BMMSA in July 2007.

Sameer Gupta, M.D., M.P.H. is a graduate of Maulana Azad Medical College and All India Institute of Medical Sciences in India, as well as the University of Alabama at Birmingham. He completed a residency in Internal Medicine at the State University of New York in Buffalo, and a fellowship in both Hematology and Medical Oncology at Temple University Hospital and Fox Chase Cancer Center. He is currently a Clinical Assistant Professor of Medicine at Jefferson Medical College. He joined BMMSA in 2011.

Molly S. Stumacher, M.D. is a graduate of Harvard University and Harvard Medical School. She completed her residence at Brigham and Women's Hospital in Boston and a fellowship in both Hematology and Oncology at the University of Pennsylvania School of Medicine in Philadelphia. Prior to joining BMMSA, Dr. Stumacher practiced at Penn Hematology-Oncology of Chester County for 12 years. She joined BMMSA in July 2018.

BMMSA's Hematology-Oncology physicians have contributed to the medical literature and are very active in clinical research. The Bryn Mawr Hospital Cancer Program provides care for over 1,000 newly diagnosed cancer patients annually, and it is affiliated with all major National Cancer Institute clinical research groups including the Eastern Cooperative Oncology Group (ECOG), National Surgical Adjuvant Breast and Bowel Project (NSABP), Radiation Therapy Oncology Group (RTOG), Gynecology Oncology Group (GOG), and with the clinical research program of the M.D. Anderson University of Texas Cancer Center.

Our office and treatment center is located in the Bryn Mawr Medial Arts Pavilion at 825 Old Lancaster Road, Suite 440, in Bryn Mawr (across from the Warden Lobby of the Bryn Mawr Hospital).

We may be reached by phone, day or night, at 610-525-4511. Our fax number is 610-525-8561. If you are a new patient, please complete the enclosed patient information form and bring it with you at the time of your initial consultation. We will obtain any pathology and radiology results from Bryn Mawr Hospital. However, we ask that you obtain relevant records, radiology and pathology reports and slides from any other hospitals and from other physicians and bring these with you at the time of your first visit (or have these faxed to us beforehand).

Relevant medical literature about your condition is available by brochure, pamphlet, etc. at our office.

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

Patient Registration Form

PLEASE PRINT CLEARLY

Date _____ Account Number _____

PATIENT INFORMATION					
Patient's Last Name:	First Name:	Middle Initial:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient's Street Address:				Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
City:	State, ZIP:	Patient's Home Phone #:	Patient's Cell Phone #:		
<u>Billing</u> Street Address of Responsible Party (if different from above):			Race: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
City:	State, ZIP:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Email:		
Employer's Name:		Work Phone #:			
Pharmacy Name, Address, and Telephone #:					
Referring Physician's Name and Telephone #:			Primary Care Physician's Name and Telephone #:		

INSURANCE INFORMATION		
<u>Primary Insurance Company Name:</u>		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:
<u>Secondary Insurance Company Name:</u>		
Identification Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:	Relationship To Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Child <input type="checkbox"/> Other	
Home Phone #:	Work Phone #:	Cell Phone #:

AUTHORIZATION AND RELEASE

* I authorize any holder of medical information about me to release this information to the Health Care Financing Administration, my insurance company or its intermediaries or carriers, or to this physician's office.

* I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Bryn Mawr Medical Specialists Association. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

* I understand that I am financially responsible for all charges whether or not paid by said insurance.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Please hand this form and your insurance cards to the Receptionist.

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BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

825 OLD LANCASTER ROAD
SUITE 320
BRYN MAWR, PENNSYLVANIA 19010

Financial Policy

We would like to take this opportunity to welcome you to our offices and assure you that we will do our utmost to provide you with the best possible care.

Patients with Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier. It is your responsibility to read and understand your insurance agreement; certain services may or may not be covered, depending on your individual policy. **Please provide current insurance information to the office, including any changes in coverage.** If your insurance requires a form, please provide one to the office. We will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for the payment of the bill.**

Portions of the bill may not be paid by the insurance company, and are to be paid by the patient. For example, a co-payment may be required by you as per your insurance agreement. If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our Business Office will gladly assist you in arranging a payment plan. If you are unable or unwilling to accept responsibility for your account balance, please be advised that your account may be forwarded to a collection agency, which will adversely affect your credit.

If you have a **High Deductible Health Plan (HDHP)**, please notify the office prior to your visit. If you have not met your deductible, we will bill you directly for any balance due. Please note, the office may request payment up front.

If you are covered through an **out-of-state insurance plan**, it is your responsibility to contact your carrier and determine if our physicians participate with your plan. Please note that these types of plans typically carry high out-of-pocket expenses.

Patients without Insurance Coverage

Patients without insurance coverage are requested to pay for services as rendered. We accept MasterCard and Visa payments.

I have read and understand the Financial Policy of Bryn Mawr Medical Specialists Association.

X _____
Signature of Patient or Guardian

Date

Account Number

Revised: January 13, 2020

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION (BMMSA)

Patient Consent for Financial Responsibility for Treatment

Patient Name: _____

Account #: _____

Date: _____

Insurance Carrier: _____

Treatment: _____

Physician: _____

I understand that I have received a recommendation for treatment for my medical condition from my physician. I also understand that sometimes an insurer, including mine, may not pay for treatment, even when recommended by my physician. The physicians at BMMSA cannot predict with certainty whether my insurer will pay for this treatment. BMMSA may have a contact with my insurer that precludes BMMSA from billing and collecting payment from me for services that my insurer refuses to pay unless I agree beforehand that I will pay for such treatment. I hereby do agree to pay for the above therapy and related costs if my insurer will not.

Patients Signature: _____

Witness (Medical Assistant): _____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE &
CONSENT TO USE HEALTH INFORMATION**

Read before signing the Acknowledgement & Consent

This acknowledgement of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices (revised 8/2013): Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgement and consent.

<http://bmmsa.com/wp-content/uploads/2013/07/bmmsa-noticeofprivacy.pdf>

If you would like to receive an additional copy of the Privacy Notice, please request one at the time of your appointment.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Bryn Mawr Medical Specialists Association
825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010
Attention: Russ Militello

Telephone: (610) 527-3800, ext. 3027

Acknowledgement & Consent

I have received the Notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialists Association is authorized to use health information about (print name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of Patient	Date	Acct#
----------------------	------	-------

Personal representative information (if applicable):

Name of Personal Representative	Relationship to Patient
---------------------------------	-------------------------

Please provide us with your contact information and the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

_____ I prefer to be contacted by my physician/physician's office at the following phone number(s) (Please circle the best daytime phone number)

Home: _____ Cell: _____ Other: _____

Do we have permission to leave a message? Yes No

_____ You have permission to speak with the designated/authorized person(s) named:

_____ You have permission to contact me via e-mail at the following e-mail address:

Print: _____

Patient's Name

Under Federal Law, as of 4/15/03, your doctors (Dr. S. Schnall, J. Devlin, S. Gupta, and M. Stumacher) cannot discuss your medical condition with anyone other than yourself (except with other medical professionals, in furtherance of your medical care) without **written** release signed by you. Thus, your doctor cannot discuss your condition with your spouse, children, siblings, etc., without your written authorization.

Please list below, any individuals with whom you give Drs. Schnall/ Devlin/ Gupta/ Stumacher permission to discuss your condition and their relationship to you (i.e. spouse, children, etc.).

_____	_____	_____
Name	Relationship	Phone

_____	_____	_____
Name	Relationship	Phone

_____	_____	_____
Name	Relationship	Phone

_____	_____
Patient's Signature	Date

MEDICAL RECORD RELEASE

**BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
HEMATOLOGY/ONCOLOGY
825 OLD LANCASTER RD, STE 440
BRYN MAWR, PA 19010
P - 610-525-4511 F - 610-525-8561**

**SANDRA F. SCHNALL MD
JOHN G. DEVLIN MD
SAMEER GUPTA MD, MPH
MOLLY S. STUMACHER MD**

PATIENT INFORMATION

NAME: _____

DOB: _____

ADDRESS: _____

TELEPHONE: _____

SIGNATURE: _____

DATE: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASE TO:

**BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION
HEMATOLOGY/ONCOLOGY
825 OLD LANCASTER RD, STE 440
BRYN MAWR, PA 19010**

Name: _____ DOB: _____

Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Welcome to the office of Drs. Schnall, Devlin, Gupta and Stumacher. In order that we may get to know you better, please complete this form and bring it with you to your visit.

What brings you to see the doctor?

Please list all of your physicians (including the physician who referred you to our office):

Please list all medications you are now taking (doses, tablet size, frequency, and approximately how long you have been on each, if possible):

Please list any medicines to which you are allergic, as well as the nature of the allergic reaction:

Medicine

Reaction

Are you allergic to intravenous dye (contrast) such as that given with CAT scans?
(circle one) Yes No

Describe your reaction to dye:

PAST MEDICAL HISTORY

Please circle and describe below all of the following surgeries, which you have had. Write the approximate year of surgery next to any circled answer.

Appendix	Prostate	Tonsils/Adenoids
Gallbladder	Hysterectomy	Oral Surgery
Kidney	Ovaries	Sinus Surgery
Stomach	Breast	Skin
Hernia	Thyroid	Broken Bones
Intestines	Eye/Cataracts	Artificial Joint
Heart	Hemorrhoid	Varicose Veins
Lung	Spine	Cancer Surgery
Neurosurgery (Brain, Spinal Cord)		

Other Surgery:

If you have been previously hospitalized, please complete:

<u>Year</u>	<u>Reason</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____

Please circle and describe below any of the following medical conditions you have had in your lifetime:

High Blood Pressure	Hepatitis	Pneumonia
Heart Attack	Gastrointestinal Disease	Emphysema
Heart failure	Angina	Hiatal Hernia
Bronchitis	Heart Murmur	Ulcer
Asthma	Leaky Heart Valve	Stomach Reflux
Pleurisy	Rheumatic Fever	Gallstones
Tuberculosis	Lyme Disease	Arthritis
Urine/Bladder Infection	Seizures	Anemia
Kidney Trouble	Nervous Disorder	Blood Transfusion
Kidney Stones	Blood Clots (Phlebitis)	Diabetes
Prostate Infection	Phlebitis	Thyroid Disease
Venereal Disease	Glaucoma	Blood Disorder
Cancer (Type: _____)	HIV	Stroke

Any other illness:

Occupation: _____

Do you smoke? Yes _____ No _____

If yes, how much do you smoke in one day? _____

If no, in the past did you ever smoke regularly? _____

How much did you smoke? _____ When did you stop? _____

Do you drink alcohol? Yes _____ No _____

If yes, please estimate the amount consumed each day: _____

If no, did you ever drink alcohol regularly in the past? _____

Have you ever been exposed to asbestos? Yes _____ No _____

Where and when? _____

Have you ever used any hormone treatment (such as estrogen, etc.)?

Yes _____ No _____

When? _____ How long? _____

Place an (x) alongside any of the following symptoms you have noticed and describe below:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> swollen feet/ankles | <input type="checkbox"/> nighttime urination | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> leg pains | <input type="checkbox"/> urgency of urination | <input type="checkbox"/> depression |
| <input type="checkbox"/> weight loss | <input type="checkbox"/> leg ulcers | <input type="checkbox"/> difficulty starting urination | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> fever, chills | <input type="checkbox"/> varicose veins | <input type="checkbox"/> loss of control of urine | <input type="checkbox"/> work/family problems |
| <input type="checkbox"/> excess sweating | <input type="checkbox"/> jaundice | <input type="checkbox"/> pus in urine | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in urine | |
| <input type="checkbox"/> trouble with vision | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> bruise or bleed easily | |
| <input type="checkbox"/> eye pain or redness | <input type="checkbox"/> special food intolerance | <input type="checkbox"/> swollen glands | MEN: |
| <input type="checkbox"/> hearing trouble | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> hot weather intolerance | <input type="checkbox"/> weak urine stream |
| <input type="checkbox"/> ear pain/discharge | <input type="checkbox"/> nausea | <input type="checkbox"/> cold weather intolerance | <input type="checkbox"/> prostate trouble |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> vomiting | <input type="checkbox"/> increased thirst | <input type="checkbox"/> discharge from penis |
| <input type="checkbox"/> nosebleeds | <input type="checkbox"/> vomiting blood | <input type="checkbox"/> increased urine volume | <input type="checkbox"/> painful/swollen testes |
| <input type="checkbox"/> nasal discomfort | <input type="checkbox"/> belching/flatulence | <input type="checkbox"/> skin problems | Date of last prostate exam _____ |
| <input type="checkbox"/> throat discomfort | <input type="checkbox"/> black stools/rectal bleeding | <input type="checkbox"/> hair/nail problems | _____ |
| <input type="checkbox"/> voice change | <input type="checkbox"/> rectal discomfort | <input type="checkbox"/> itching | Dr. who performed last prostate exam _____ |
| <input type="checkbox"/> dental/gum symptom | <input type="checkbox"/> diarrhea | <input type="checkbox"/> headaches | Was it normal? Yes No |
| <input type="checkbox"/> cough | <input type="checkbox"/> backache | <input type="checkbox"/> dizziness | Date/value of last PSA _____ |
| <input type="checkbox"/> sputum | <input type="checkbox"/> arthritis/joint pain | <input type="checkbox"/> fainting | _____ |
| <input type="checkbox"/> chest pains | <input type="checkbox"/> "bursitis" | <input type="checkbox"/> numbness, pins/needles | |
| <input type="checkbox"/> wheezing | <input type="checkbox"/> muscular aches | <input type="checkbox"/> tremor | |
| <input type="checkbox"/> heart "skipping" | <input type="checkbox"/> burning on urination | <input type="checkbox"/> muscle weakness/paralysis | |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> frequency of urination | <input type="checkbox"/> seizures, convulsions | |
| <input type="checkbox"/> pain | | <input type="checkbox"/> faulty memory | |
| <input type="checkbox"/> lumps | | | |

MEN:

- weak urine stream
 - prostate trouble
 - discharge from penis
 - painful/swollen testes
- Date of last prostate exam _____

Dr. who performed last prostate exam _____
Was it normal? Yes No
Date/value of last PSA _____

WOMEN:

- trouble with menstruation
 - vaginal discharges
 - hot flashes
 - breast lump/discharge
- Date of last period _____
Date of last mammogram _____

Location of last mammogram _____

Was it normal? Yes No
Date of last Pap test _____

Dr. who performed Pap _____

Please describe any other symptoms:

Date of last rectal/hemoccult (test for blood in stool) exam _____ Was it normal? Yes _____ No _____

Doctor who performed rectal/hemoccult exam _____

Please fill in your family history:

<u>RELATIVE</u>	<u>AGE IF LIVING</u>	<u>CAUSE OF DEATH IF DECEASED</u>	<u>AGE AT DEATH</u>	<u>MEDICAL PROBLEM</u>
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____
	_____	_____	_____	_____
SPOUSE	_____	_____	_____	_____
CHILDREN	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Please describe any cancer history in your family (or any other important family history not listed above):

Please include if you have had depression, alcohol, or drug difficulties or unusual anxiety:

An Oncology social worker is available free of charge in our practice for individual/family counseling, coping with your diagnosis, insurance or employment issues, community resources and to work with children whose parents are going through cancer treatment.

Please check if you would like to be seen by the social worker.

Our practice has access to the latest clinical trials which may pertain to your condition. Please check here if you would be interested in hearing about these clinical trials.

Is there anything else you think we should know?
