PARKINSON'S. WE'RE IN THIS TOGETHER.™

Please accept this letter as our initial welcome to you as a patient at the Parkinson's Institute and Clinical Center!

Please fill out the enclosed patient registration forms and return them **prior** to your appointment.

General information for the day of your appointment:

- Please check in at the clinic at least thirty minutes prior to your scheduled appointment time.
- Please read the *Patient Consent Form*. If you agree to our Clinic policies and you would like to be treated by one of our Doctors, please sign and date the *Patient Consent Form*. You may use the *Patient Consent Form* to specify any restrictions on our communications with you.
- Please read and sign the *Notice of Privacy Practices* form.
- Please bring your insurance card(s) and driver's license to be scanned in to our Electronic Medical Records system. Insurance Companies we currently contract with are Aetna, Anthem Blue Cross PPO, Blue Shield of California PPO, Cigna, Health Net, Medicare Part B and United Healthcare. If you have Medicare coverage, we will bill Medicare for you and we do accept assignment. If you have other types of insurance, we will bill your insurance company to assist you in getting reimbursed. Please read the *Patient Financial Agreement Form* for further information.
- **Self-paying patients are required to pay in full on day of service.**
- **Insurance co-pays are due in full on day of service.**
- Your visit will take approximately 90 minutes. This includes check in as well as your physician taking a medical history, assessing current medical problems, performing a comprehensive medical test which includes a neurological examination, and developing a plan of care that will be sent to your referring physician.

We are located at **675 Almanor Avenue** in **Sunnyvale, California**. There is plenty of parking for your convenience. If you have any questions, please feel free to call **(408) 734-2800** to reach the Clinic.

We look forward to meeting you!
On behalf of the Clinic Team

Anthony Santiago, MD
Chief Medical Officer

Anthony Mosley, MD
Movement Disorders Specialist

Kristin Andruska, MD, Ph.D.
Movement Disorders Specialist

Parkinson's Institute and Clinical Center

675 Almanor Avenue
Sunnyvale, California 94085

Movement Disorders Clinic
(408) 734-2800 main
(408) 734-9208 secure fax

ParkinsonsInstitute.org
PDpartner PDpartner

Patient Questionnaire

Today's Date:_____

Last Name _____ First Name _____ MI ____

Birth Date _____ Social Security # _____

Home Address (City State Zip code)

_____

_____

Home Phone ( ) _____ OK to leave voicemail yes □ no □

Work/Cell ( ) _____ OK to leave voicemail yes □ no □

Email_____

Marital Status: □ Single □ Divorced □ Widowed □ Married/Partnered (name) _____

Race (optional): □ White □ African-American □ Hispanic □ Asian/ Pacific Islander □ Other_____

OPTIONAL

Designated person(s) authorized to discuss your medical information with clinic staff. Indicate name, relation and phone number. Patient must sign to be valid.

_____

Patient Signature: _____

INSURANCE INFORMATION

Primary Insurance Information
Subscriber's name
Insurance Company
Plan Type, Please circle one: PPO EPO MC HMO (EPO, MC, HMO will require prior authorization or payment must be made in full day of service)

Secondary Insurance Information
Subscriber's name
Insurance Company
Plan Type, Please circle one: PPO EPO MC HMO (EPO, MC, HMO will require prior authorization or payment must be made in full day of service)

PHYSICIAN INFORMATION

Please complete the following and check off the contacts to which you want us to send the report. Information must be filled out completely in order for our office to send report.

☐ Primary Care Physician Name:	☐ Neurologist Name:
Address	Address
City	City
State Zip	State Zip
Phone ( )	Phone ( )
Fax ( )	Fax ( )

☐ Other Name:
Address
City
State Zip
Phone ( )
Fax ( )

PHARMACY INFORMATION in preferred order

Name		
Address		
City	State	Zip Code
Phone ( )	Fax ( )	

Name		
Address		
City	State	Zip Code
Phone ( )	Fax ( )	

Name		
Address		
City	State	Zip Code
Phone ( )	Fax ( )	

Patient History

Reason for today's visit (diagnosis?): _____

Date of diagnosis: _____

What was/were your first symptom(s)? _____

When did symptom(s) occur? _____

Who diagnosed you with the above condition(s)?

□ Primary Care Physician □ Neurologist □ Other_____

MEDICAL HISTORY:

Do you have other medical problems or illnesses requiring treatment? □ No □ Yes (describe):

Past:_____

_____

_____

Current:_____

_____

_____

Surgeries, significant trauma, or hospitalizations? □ No □ Yes (please describe, indicate year):

_____

_____

_____

SOCIAL HISTORY:

Years of education/highest degree: _____

Most recent/primary occupation: _____

□ Currently working □ Retired (year) _____

Living situation:

□ At home (with: _____) □ Assisted living □ Nursing facility □ Board and care

Smoking: □ Never □ Yes □ Yes, but quit (date: _____)

*If yes – Cigarettes/Packs per day: _____ and for how many years: _____

Alcohol: □ Never □ Yes □ Yes, but Quit (date: _____)

*If yes - Drinks/ week: _____ and # of years: _____

Recreational Drugs: □ Never □ Yes (describe): _____

Are you currently driving? □ No □ Yes

IMMUNIZATION HISTORY: please list date of last vaccine.

Influenza (flu) _____ Pneumococcal (pneumonia) _____

FAMILY HISTORY: Please indicate family members (parents, siblings, children, grandparents, aunt/ uncles/ cousins) with any of the following medical conditions:

Parkinson's disease	Stroke
Tremor	Alzheimer's
Dementia	Depression
Mental Illness	Other neurological disorder
Other movement disorder	Other genetic disorder

Handwriting Exam

Name: _____ Date: _____

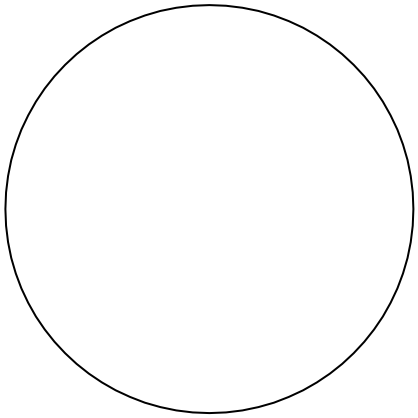
☐ Right handed
☐ Left handed

Sign your name:

Please write the following: “Today is a nice day.”

Write any sentence you would like, as long as it is a complete sentence.

Put in the numbers of the clock



Draw the clock’s hands to show 7:15

Medication List

(Please include all over the counter medications and supplements, use more paper if necessary)

Name:_____ Date:_____

- Please list all the medications that you are currently taking.
- Please list all previous medications that you have tried for the condition you are here for but have discontinued. Please provide reason for discontinuation.
- Include strength, the time(s) that you are taking them each day, and the number of tablets at each time.

EXAMPLE	Time	Time	Time	Time	Time	Time	Time	Time
Current Medications/ Strength	8:00 am	12:00 pm	4:00 pm	8:00 pm	:	:	:	:
Sinemet 25/100	1 pill	2 pills	1 pill	2 pills				

CURRENT MEDICATIONS

	Time	Time	Time	Time	Time	Time	Time	Time
Medication / Strength (mg)	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm

PREVIOUS MEDICATIONS

Medications / Strength(mg) (List only neurological medications)	Reason for Discontinuation	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm

ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes (if yes – please describe allergies and reactions)

Patient Consent Form

(to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations)

I, _____ (please print full name), understand that as part of my health care, the Parkinson's Institute and Clinical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means of communication among many health professionals who contribute to my care
- Source of information for applying my diagnosis and surgical information to my bill
- Means by which a third-party payer can verify that services billed were actually provided
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

In order to provide high-quality services, activities that the Parkinson's Institute and Clinical Center carries out include: appointment reminder telephone calls and postcards, videotape and photograph, returning patient phone calls, referrals to other physicians, and sending medical records to transcription services, other physicians' offices, insurance companies, state agencies, the patient, and designated relatives.

The Parkinson's Institute and Clinical Center wants to keep patients and their families and caregivers updated on latest developments. Patient support is paramount to the Institute. Thus, newsletters will be mailed regularly and patients will be placed on a donations database, unless specified otherwise. To determine eligibility for upcoming clinical trials, patients will be placed into a Clinical Trials database if they provide verbal or written/electronic consent.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient

and no longer protected by this rule.

I understand that the Parkinson's Institute and Clinical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent by writing to the Privacy Officer except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Parkinson's Institute and Clinical Center reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Parkinson's Institute and Clinical Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I fully understand and accept / decline (please circle one) the terms of this consent.
I acknowledge that I have received and reviewed the Notice of Privacy Practices.

Patient's Signature _____ Date _____

Notice of Privacy Practices

At the Parkinson's Institute and Clinical Center, we are committed to protecting your health information. The Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality and security of your health information. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information (PHI). This revised Notice is effective April 15, 2014 and remains in effect until we replace it. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Protected health information is the information we create and obtain in providing our services to you. Such information includes documentation of your symptoms, examination and test results, diagnoses, treatment, and plans for continued care. It also includes billing documents for those services. Our office is permitted by federal privacy laws to use and disclosure your health information for the purposes of treatment, payment, and health care operations.

You have a right to:

1. Consent to use your PHI for Treatment, Payment, or healthcare Operations (TPO)
2. Request a restriction on certain uses and disclosures of your information. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Appoint another person to consent to or authorize disclosure of your PHI.
4. Obtain a copy of this notice upon request.
5. Inspect and copy your health record for a reasonable, cost-based fee. Submit requests in writing to the Privacy Officer. The request will be processed within 30 days.
6. Amend your health record if you believe that it is incorrect or incomplete. Submit requests in writing to the Privacy Officer, with a reason that supports the request. The physician must make the amendment within 60 days. If the physician denies the request, you may write an objection to the denial, and require that all communications be documented and attached to future disclosures of PHI.
7. Ask us not to share your PHI if you pay for a service or health care item out-of-pocket in full. We will say “yes” unless a law requires us to share that information.
8. Receive an accounting of certain disclosures we have made of your health information if you provide a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
9. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
10. Request how and where we contact you regarding your health information.

Our Responsibilities

The Parkinson's Institute and Clinical Center is required by law to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice, which is now in effect,
4. Notify you if we are unable to agree to a requested restriction,

5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations, and
6. Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the Parkinson's Institute and Clinical Center's Privacy Officer at (408) 734-2800.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Email: OCRComplaint@hhs.gov

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a physician, nurse or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We may also provide your other health care providers with copies of reports to assist them in treating you.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, visit details, and procedures or supplies used during the visit.

We will use your health information for our regular health operations.
Health care operations are any of the following activities: (a) Quality assessment and improvement activities, including care coordination; (b) Competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) Conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; and (d) Specified insurance functions, such as underwriting, risk rating, and reinsuring risk. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your PHI.

Notification.
Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Research.
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors.
We may disclose health information to funeral directors consistent with applicable law to carry out their duties. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing and Fundraising.
We may contact you to provide appointment reminders, information about treatment alternatives, or information about other health-related benefits and services that may be of interest to you. We may contact you to ask for your help with different fund raising campaigns. Please notify us if you do not wish to receive such communications and we will not use or disclose your information for these purposes.

Workers compensation.
We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health.
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect. We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Victims of Abuse, Neglect, or Domestic Violence.
We may disclose PHI to appropriate authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your PHI if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

Law enforcement.
We will share information about you with law enforcement official or health oversight agencies if state or federal laws require it. We will share information with the Department of Health and Human Services if they want to verify that we're complying with the federal privacy law.

Specialized Government Functions.
Subject to certain requirements, we may use or disclose PHI for military personnel and veterans, to federal officials for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

One-Time Patient Financial Agreement

I _____ (please print full name) hereby authorize **Parkinson's Institute and Clinical Center** to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to **Parkinson's Institute and Clinical Center** on my behalf.

Parkinson's Institute and Clinical Center is a participating provider with Medicare part B, Blue Shield of California (PPO only), Blue Cross (PPO only) Aetna (PPO only), United Health Care (PPO only), PHCS, Interplan, and First Health.

1. By contract, covered charges will be paid directly to Parkinson's Institute and Clinical Center. I understand that any applicable co-insurance or deductible payments are my responsibility. These will be billed to me after my insurer has considered the claim.
2. Parkinson's Institute and Clinical Center is not a provider to any HMO programs. I understand that if I am an HMO participant/patient, I am responsible for obtaining an authorization from my primary care physician prior to my visit(s). If I have not obtained authorization for my initial or any subsequent visit(s), I will be required to pay in full at the time of service.
3. I understand that I am financially responsible for all non-covered, non-authorized or denied charges incurred on my behalf.
4. A copy of this agreement may be used in place of the original. This is a one-time agreement and shall remain in effect while I am a patient in the Movement Disorders Clinic at the Parkinson's Institute and Clinical Center.

If you are not sure what your insurance covers please call your insurance carrier prior to your visit.

It is your responsibility to inform the Parkinson's Institute and Clinical Center of any changes to your medical insurance policies.

Co-pays are due in full day of service.

CANCELLATION AND MISSED APPOINTMENT POLICY

Our Cancellation and Missed Appointment Policy has been put in place to enable us to better utilize available appointments for our patients. We understand that there are times when you must re-schedule or miss an appointment due to emergencies or obligations. If it is necessary to cancel your scheduled appointment please call the Parkinson's Institute and Clinical Center at least 24 hours in advance of the appointment.

Available appointments are in demand and your early cancellation will give another person the possibility to have access to timely treatment and care. When an Initial Evaluation appointment is not cancelled at least 24 hours in advance or you do not attend your appointment you will be charged a one-hundred ($100) fee, and for a follow-up appointment a fifty dollar ($50) fee will be charged. These fees are not typically covered by your insurance plan.

I have read, understand, and agree to the above.

_____ _____

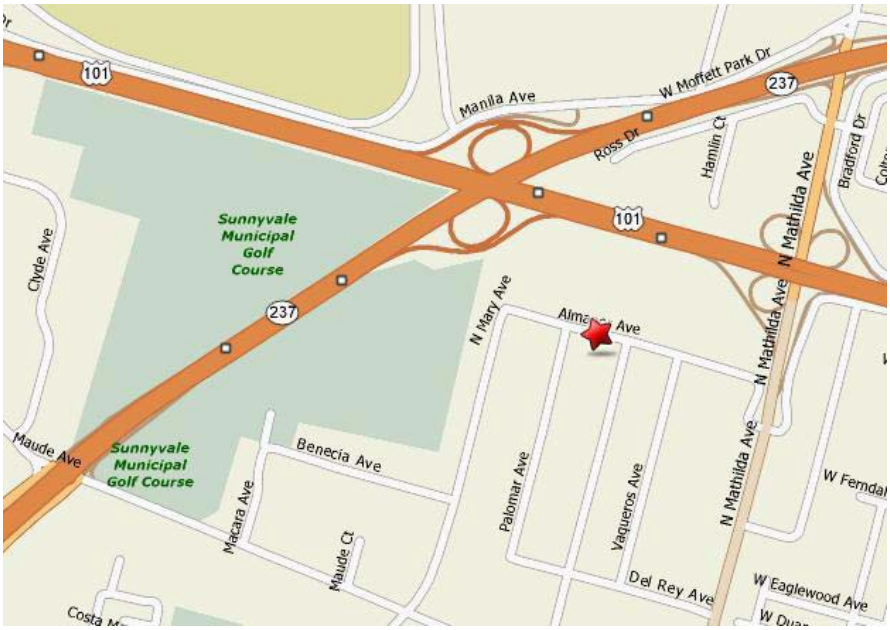
Patient's Signature Date

Directions

Parkinson's Institute and Clinical Center
675 Almanor Avenue, Sunnyvale, CA 94085

Toll Free phone numbers:
In California: 800.655.2273
Outside California: 800.786.2958

Clinic Fax Number: 408.734.9208
Clinic: 408.542.5697



DIRECTIONS TO THE INSTITUTE:
If you get stuck or need assistance, call us at 408.734.2800 - the receptionist will help you.

From San Jose -
> Take US-101 N. toward San Francisco
> Take the MATHILDA AVENUE SOUTH exit (toward Sunnyvale)
> At first stoplight, IMMEDIATELY turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Palo Alto -
> Take US-101 S toward San Jose.
> Take the MATHILDA AVENUE exit (stay to the right)
> At first stoplight, IMMEDIATELY turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Highway 237 West (from Milpitas) -
> Take the MATHILDA AVE exit toward US-101 S / SUNNYVALE.
> Turn LEFT onto N. MATHILDA AVE.
> Turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Highway 237 East (from Mountain View) -
> Exit onto N. MATHILDA AVE (make a right onto N. Mathilda Ave.) toward Sunnyvale.
> Turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

PARKINSON'S. WE'RE IN THIS TOGETHER.™

To: _____

_____

_____

Please release my medical records to:

Parkinson's Institute and Clinical Center
675 Almanor Avenue, Sunnyvale, CA 94085
Phone: (408) 734-2800 Fax: (408) 734-9208

Records pertaining to the diagnosis of:

- Original History & Physical
- MRI reports and films
- Consultation reports
- Past year's doctors' notes (including muscle testing & UPDRS)
- Most recent History & Physical
- Recent laboratory reports

Purpose of Disclosure:

☐ New patient referral ☐ Continuity of care ☐ Other_____

Date of Expiration:

This authorization shall remain in effect _____ or for one year from the date of signature.

Revocation of Request:

This authorization is also subject to written revocation by the undersigned at any time between now and disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the request or others have acted in reliance upon this authorization.

Minimum Necessary Standard:

The Protected Health Information requested is the minimum necessary to accomplish the specified purpose.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient's Signature (or Legal Representative) Today's Date

Parkinson's Institute and Clinical Center
675 Almanor Avenue
Sunnyvale, California 94085

Movement Disorders Clinic
(408) 734-2800 main
(408) 734-9208 secure fax

ParkinsonsInstitute.org
PDpartner PDpartner

Dr. **David Marsden** wrote the following **letter**, which was published in the United Parkinson's Foundation newsletter (#4, Part 2) in 1986. We thank UPF for permission to reprint the article.

Autopsies, Tissue Donations, and Brain Banks

It is not pleasant to contemplate one's own death, but it is one of life's two inevitabilities (the other being taxes!). Yet this final event is an opportunity to leave a priceless legacy to others. By donating our kidneys, livers, and hearts for transplantation, we can give the gift of life to those whose own organs need replacing. What about our brains? Allowing our brains to be used for research may one day contribute to discoveries that my lead to a cure for our family members or friends.

Diseases of the **brain** are the most difficult to study. We do not notice loss of a small part of our kidneys or liver. Doctors can remove a piece of kidney during life by a needle biopsy. The tiny core of tissue can be examined under the microscope or chemically. On the other hand, each part of the **brain** is unique. So we cannot remove pieces of the **brain** from the living, but must rely on the dead for tissue to study. This is why the gift of our brains after death is so crucial to research.

The discovery of Levodopa treatment for symptoms of Parkinson's disease (PD) came directly from chemical examination of the brains of patients after death. Demonstrations of the considerable loss of dopamine in the basal ganglia in patients with PD was the stimulus to use levodopa to try to replace the missing dopamine. Levodopa treatment has had a dramatic effect upon the quality of life in PD patients but it is not a cure. However, now there are real clues as to what might be the cause(s) of the illness, and the need for brains to study is all the more urgent.

Twins studies have shown that, in general, inheritance does not play a direct role in causing PD. So we must look to the environment. The remarkable MPTP story has shown that toxic substances are capable of producing parkinsonism, and the hunt is on for other such toxins. But we need to look for such agents and their effects within the brains of those with Parkinson's disease.

If you are persuaded by these arguments, then you need to take action now. Arrangements must be made in advance to ensure that the **brain** tissue is preserved as soon as possible after death. Your relatives, doctors, and attorneys must know of your wishes ahead of time so that there is no uncertainty. It is best to have all this settled, in writing.

At first sight, all this sounds as if it is directed only at the patients with Parkinson's disease, but there is an equally pressing need for **brain** tissue from normal subjects as well. We can only tell what is wrong in PD by comparing parkinsonian **brain** tissue to tissue from normal brains. So the normal spouses, relatives, and friends of those with Parkinson's disease can make a major gift of their own brains to help the study of this illness.

How can you get more information regarding the donation of brain tissue? The Parkinson's Institute Brain Donation Program is one of the largest of its kind in the country. We are happy to answer any questions you may have, and if interested, enroll you into the Program. For more information, please contact the Parkinson's Institute Brain Donation Program Coordinator.

By phone*: 408-656-1599* *Or* *By email:* *braindonation@thepi.org*

Parkinson's Institute and Clinical Center
675 Almanor Avenue
Sunnyvale, California 94085
Movement Disorders Clinic
(408) 734-2800 main
(408) 734-9208 secure fax
ParkinsonsInstitute.org
PDpartner PDpartner