PLEASE ONLY USE BLUE OR BLACK INK

Dear Patient,

Welcome to Rocky Mountain Movement Disorders Center, P.C and thank you for scheduling your appointment with us. Our mission and goal is to provide the highest quality, most state of the art care, for all patients and families affected by movement disorders. The road to improving your quality of life begins here.

Please fill out the forms provided in this packet and bring them with you to your First appointment. Along with these forms, please plan to bring the following items with you to your appointment:

- Insurance card(s) –Including your Medicare and Medicaid cards if you have them.
- Driver's license or state photo ID card.
- Payment for your visit co-pay, if applicable.
- All original medication bottles for medications currently prescribed.
- If available, Power of Attorney (POA) and/or Advanced Directive forms.

If you have not already sent the following items or provided the information to our office, please plan to do so at the time of your appointment:

- Primary care physician's full name, address telephone, and fax numbers.
- Referring physician's full name, address, telephone, and fax numbers.
- MRI reports and films/CD's; CT reports and film/CD's
- Any other reports pertaining to your care.

***Very Important:** Do **NOT** bring your own medication list. Please fill out the medication list our office has provided for you in this new patient packet. This form is specifically designed to aid our providers in providing you the best possible care.

If you have any questions or concerns regarding any of the requested documents, anything pertaining to your new patient packet, or if you have general questions regarding our practice, please do not hesitate to call our office prior to your appointment. You may also visit our website at www.movementdisordscenter.org to learn more about our clinic and our staff.

Sincerely,

RMMDC Providers, Management, & Staff

ROCKY MOUNTAIN MOVEMENT DISORDERS CENTER

Rajeev Kumar, MD
Medical Director

Vicki Segro, MSN, C-ANP
Nurse Practitioner

Josette Pressler, LPN

Jessica Jaynes, BS, CCRC
Research Coordinator

Peggy Hugger, RN
Research Coordinator

Karen Abou-Samra, RN, CCRC
Research Coordinator

Janell DeGiorgio
Research Coordinator

Rin Nelson
Research Coordinator

Liza Heap, BS, BA
Research Coordinator

National Parkinson Foundation Care Center

NATIONAL PARKINSON FOUNDATION

Huntington's Disease Society of America Center of Excellence

Huntington's Disease Society of America

701 East Hampden Avenue
Suite 510
Englewood CO 80113-2759
(303) 357-5455 Phone
(303) 357-5459 Fax
www.movementdisorderscenter.org

Rocky Mountain Movement Disorders Center, P.C.

701 E Hampden Ave, Ste. 510 Englewood CO 80113
(303) 357-5455 Fax: (303) 357-5459

Patient Demographic Information

Patient Name:_____ DOB_____ Gender: M / F

Social Security #:_____-_____-_____ Marital Status_____

Mailing address_____

City_____ State_____ Zip _____

Phone # _____ Cell Phone _____ Work Phone_____

Email address _____

(We do not sell, or advertise your email address to any other firm – This is for our Patient Portal purposes)

Primary Care Physician (PCP)_____ PCP Phone_____

Address _____

PCP Fax _____ _____

Referring Physician _____ Ref. Phys Phone_____

Address_____

Ref Phys Fax _____

Pharmacy_____ Pharmacy Phone _____ Fax_____

Address_____

Employment Status: FT/PT/Student/Retired/Unemployed Employer_____

Emergency Contact_____ Relationship_____

Emergency Contact Phone_____ Cell Pone_____ Work _____

Insurance Information

Primary Insurance Company_____ ID# _____

Group # _____ Primary Insured's Name _____

Primary Insured's DOB_____

Secondary Insurance Company_____ID# _____

Group # _____ Primary Insured's Name _____

Primary Insured's DOB _____

****

Please read and sign the following Assignment of Benefits.

I hearby authorize assignment of benefits directly to Rocky Mountain Movement Disorders Center, P.C. for all my insurance claims related to services provided to me. I agree to pay all charges that exceed my insurance coverage and/or charges not covered by my insurance carrier.

I understand that copayments, deductibles, and non-covered services are due at time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance carrier.

I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

Rocky Mountain Movement Disorders Center, P.C.

Patient Authorization for the Use & Disclosure of Protected Health Information

I hereby give my consent to Rocky Mountain Movement Disorders Center, P.C. (RMMDC) to use and disclose protected healthcare information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I also hereby give my consent for treatment by the physicians of RMMDC.

I have the right to review the Notice of Privacy Practices prior to signing this consent and any time thereafter.

With this consent RMMDC may do the following: *(Please select yes or no from each statement below)*

- May call my home and leave message on voicemail: Yes ◯ No ◯
- May call my place of employment and leave message on voicemail: Yes ◯ No ◯
- May call my cell phone and leave message on voicemail: Yes ◯ No ◯

Give authorization for review of my medical records to all appropriate clinic personnel regarding clinical trials. (For complete description, please see receptionist for a copy of our Notice of Privacy Practices/HIPAA).

Please list the individuals with whom we may communicate regarding your treatment at RMMDC, (i.e. family members, caregivers, etc.). Please list alternative phone numbers for family members if necessary.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

By signing this form, I am consenting RMMDC's use and disclosure of my PHI to carry out TPO. I understand that this form will remain in effect until revoked. I may revoke or change my consent at any time.

Patient Name (please print) Patient (or responsible party) Signature

Responsible Party Name (Please Print) Date

Rocky Mountain Movement Disorders Center, P.C.
Notice of Privacy Practices

Effective Date: February 1, 2017

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

If you have any questions about this notice, please contact our Privacy Officer, Rocky Mountain Movement Disorders Center, PC, 701 E. Hampden Avenue, Suite 510, Englewood CO 80113, phone: (303) 357-5455, Fax: (303) 357-5459.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for services provided to you
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. For example, our research coordinators may review your personal health information to help them identify patients who might be suitable candidates for a research study. You may also be contacted by our office to inquire if you wish to participate in a research study.

We may also 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.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions, such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:
  www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Acknowledgment of Receipt of this Notice

Rocky Mountain Movement Disorders Center, PC is committed to treating and using your protected health information in a responsible manner. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information as permitted by law.

I acknowledge that I have received the Notice of Privacy Practices for Rocky Mountain Movement Disorders Center, PC

Name of Patient (PRINT) _____

_____ _____

Signature of Patient or Authorized Representative Date

If signed by patient's Authorized Representative, please print your name below and indicate your relationship to the patient.

_____ _____ Name of

Authorized Representative (PRINT) Relationship to Patient

Rocky Mountain Movement Disorders Center, PC is authorized to release and discuss my health information with the following individuals.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Patient refused to sign

___Patient was unable to sign because _____

___Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity

___Other reason: _____

_____ _____

Employee Signature Date

Rocky Mountain Movement Disorders Center, P.C.
Rajeev Kumar, M.D.
701 E. Hampden Ave Suite 510
Englewood CO 80113

Financial Policy/Consent for Payment

I understand that my insurance company may or may not pay for services rendered to me by Rocky Mountain Movement Disorders Center, P.C. (RMMDC) I also understand that I am responsible for copayments, co-insurance amounts, and any in/out of network deductibles that I may owe. I am also responsible for any referrals and pre-authorizations required by my insurance carrier(s).

I agree to be 100% responsible for payment if my insurance denies reimbursement for my claims. An authorization, pre-certification, or verification of eligibility is not a guarantee of payment.

All payments will be made to RMMDC by cash, check, or a major credit card.

It is the policy of RMMDC to hold a valid credit card number (Please see attached form). I understand that if I fail to comply with this policy, I may be denied treatment or care from RMMDC. I further understand that RMMDC may automatically bill my credit card for my unpaid account balances over 90 days old.

Hospice Patients

If you are currently under Hospice care: Please be advised that unless you have pre-arranged the visit to our clinic with your hospice provider, your visit will not be covered by your insurance carrier and you will be responsible for all charges incurred.

Payment Arrangements and Expectations

Rocky Mountain Movement Disorders Center, P.C., requires payment due at the time services are rendered. In the event you need to make special payment arrangements, our policy is to collect payment in-full within three (3) months. If your account becomes delinquent and we are unable to collect your debt, we may transfer your account to an outside collection agency. Should your account be transferred to a collection agency, you will be responsible for any associated collection fees and you may also be discharged from treatment and care from RMMDC.

No-Show, Cancelation, and Administrative Fees

There may be a $75.00 fee assessed to your account if you fail to call and cancel your appointment within 48 hours of your scheduled appointment time. There will also be a $75.00 fee assessed to your account if you fail to show up for your appointment.

Our office may also charge the following Administrative Fees:

- Returned checks: $30.00
- Completion of forms: $50.00
- Medical Records: $25.00

The financial and insurance information provided by me to RMMDC is true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and cost of collection, in the event of account default. I also authorize RMMDC to furnish or obtain any/all information to/from insurance carriers, Social Security Administration (Medicare), the referring physicians, or other agencies to which RMMDC refers and designated family members or caregivers concerning my illness and treatments. I authorize my insurance company to send claim payments directly to RMMDC. I further understand that this signed policy will remain in effect until revoked.

_____ _____

Patient Name (Please Print) Patient (or responsible party) Signature

_____ _____

Responsible Party Name (Please Print) Date

Rocky Mountain Movement Disorders Center, P.C.

Rajeev Kumar MD
701 E Hampden Ave Suite 510
Englewood CO 80113

CREDIT CARD ON FILE FORM

As stated in the Financial Policy of Rocky Mountain Movement Disorders Center P.C. (RMMDC), it is the policy of RMMDC to acquire a valid credit card number to be kept on file. RMMDC will keep your credit card information private and secure. At no time will RMMDC share your credit card information with any outside agencies.

By signing below, you agree and understand that you may be denied treatment or care from RMMDC if this information is not obtained and kept current.

I authorize RMMDC to automatically bill my credit card for any unpaid account balances that are over 90 days old.

I further authorize RMMDC to charge my card .01 for verification purposes. This authorization will remain in effect until the card on file expires, at which time it is my responsibility to provide a new card to RMMDC.

_____
Patient Name (Please Print)

_____
Name on Card

_____
Card Type

_____
Card Number

_____
Expiration Date

_____
Security Code

_____
Billing Zip Code

_____
Signature

_____
Date

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave Ste 510
Englewood CO 80015

Medication List

Rajeev Kumar, M.D.
Vicki Segro, MSN C-ANP
Phone (303)357-5455
Fax (303)357-5459

Please write the quantity of tablets taken at each time frame
(ie. 2 tablets taken at 8am, note the number 2 in the 8AM box)

Patient Name:_____

Date of Birth:_____

Date:_____

Please fill out all *non-prescription* drugs and supplements on the back

Pharmacy Information- **Local:** **Mail Order:**

Prescription Medications	Strenght	Form	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	NOON	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM
Example	40 mg	capsule									2				1								1			
List all medications prescribed by our office first																										

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave Ste 510
Englewood CO 80015

Medication List

Rajeev Kumar, M.D.
Vicki Segro, MSN C-ANP
Phone (303)357-5455
Fax (303)357-5459

Non-Prescription Drugs and Vitamins/Supplements

Medication/Supplements	Strenght	Form	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM

Patient Medical History

Name:_____ DOB:_____

Occupation: _____ Retired:_____ Disabled:_____

Right Handed: _____ Left Handed: _____

Reason for today's visit: _____

_____

Allergies to Medications (describe reaction): _____

_____

Please check any of the following medical diagnoses you have or have had in the past:

Diabetes: _____ Cancer (type/treatment): _____ Liver disease: _____

High blood pressure: _____ Heart disease: _____ Heart attack: _____ Kidney disease: _____

Asthma: _____ Lung disease: _____

Other (describe): _____

_____

Psychiatric History:

Depression: _____ Bipolar disorder: _____ Anxiety disorder: _____ Conversion disorder: _____

Other psychiatric diagnoses or hospitalizations: _____

_____

Surgical History: *Please list all prior surgeries and dates*

Gall bladder removal: _____ Bladder surgery: _____ Shoulder surgery: _____

Appendix removal: _____ Hysterectomy: _____ Cervical spine (neck): _____

Tonsil removal: _____ Prostate Surgery: _____ _____

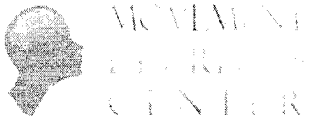
Cataracts: _____ Knee Surgery: _____ Lumbar spine (low back): _____

Heart surgery: _____ Hip surgery: _____ _____

Other surgeries: _____

_____

Please use blue or black ink to fill out (No pencils or colored pens)



Family History

Please list all family medical conditions – If the family member is deceased, please state:

Father: _____

_____

Mother: _____

_____

Sisters: _____

_____

Brothers: _____

_____

Do you have children? _____ List names and ages of children: _____

_____

Is there anyone in your immediate family with neurologic conditions, Parkinson's disease, dementia, tremor, dystonia, tics, Tourette syndrome, restless legs syndrome or other movement disorders? _____

_____

_____

Do you have any other significant family medical conditions? Describe: _____

_____

Social History

Marital Status: _____

Do you smoke? Yes: _____ No: _____ Quit: _____ Packs per day: _____ How long? _____

Do you drink alcohol? Yes: _____ No: _____ Amount and frequency: _____

Do you use Marijuana? Yes: _____ No: _____ Amount and frequency: _____

Do you currently or have you in the past used other drugs such as cocaine, amphetamines, methamphetamines, LSD, barbiturates? _____

Provide the name, phone # and fax # of the providers you would like us to send the report:

_____

_____

_____

Please use blue or black ink to fill out (No pencils or colored pens)

Review of Systems Form

Review of Systems

1) Eyes, Ears, Nose
   a) Vision problems/glasses yes no
   b) Nose/sinus/polyps yes no
   c) Hearing /hearing aids yes no
2) Cardiac
   a) Chest pain/heart attack yes no
   b) Heart failure yes no
   c) Heart surgery yes no
   d) High blood pressure yes no
   e) Palpitations/fainting yes no
   f) Blood clots yes no
3) Gastrointestinal
   a) History of ulcers yes no
   b) History of heartburn yes no
   c) Difficulty swallowing yes no
   d) Vomiting yes no
   e) Constipation or diarrhea yes no
   f) Blood in stool yes no
4) Genito-urinary tract
   a) Kidney disease yes no
   b) Urinary tract infections yes no
   c) Urinary incontinence yes no
   d) Prostate disease yes no
5) Musculoskeletal
   a) Arthritis yes no
   b) Gout yes no
   c) Muscle pain yes no
6) Hematologic/lymphatic
   a) Anemia yes no
   b) Bleeding disorder yes no
   c) Legs swelling yes no
   d) Cancer (type) _____ yes no
7) Neurologic
   a) Headaches yes no
   b) Stroke yes no
   c) Seizure disorder yes no
   d) Numbness/tingling yes no
   e) Weakness yes no
8) Skin
   a) Rashes yes no
   b) Eczema/psoriasis yes no
   c) Skin cancer (type) _____ yes no
9) Psychiatric
   a) Anxiety yes no
   b) Depression yes no
   c) Other psychiatric illness (type) _____
10) Endocrine
   a) Thyroid disorder yes no
   b) Diabetes yes no
11) Sleep
   a) Snoring yes no
   b) Daytime sleepiness yes no
   c) Morning headache yes no
   d) Insomnia yes no
   e) Sleep apnea yes no
   f) Use of CPAP/BiPAP/O2 yes no
12) Respiratory
   a) Shortness of breath yes no
   b) Cough yes no
   c) Change in voice yes no
   d) Allergies/asthma yes no
13) General
   a) Change in weight yes no
   b) Fever/chills yes no
   c) Night sweats yes no
   d) Fatigue yes no

Parking Information

** Complimentary Valet Parking At:

701 E. Hampden Avenue

- Available Monday Through Friday
- 7:30am – 5:00pm

** Complimentary Self-Parking At:

South Parking Garage:
Across From The Main Hospital Entrance

The South garage is located on Old Hampden, across from the main entrance to the hospital. It offers a covered walkway from the second floor of the structure over into the 701 E. Hampden Medical Office Building. To get to our office take the bridge across. Take a right. Then take the elevator up to the 5th floor.

ROCKY MOUNTAIN MOVEMENT DISORDERS CENTER

Rajeev Kumar, MD
Medical Director

Vicki Segro, MSN, C-ANP
Nurse Practitioner

Josette Pressler, LPN

Jessica Jaynes, BS, CCRC
Research Coordinator

Peggy Hugger, RN
Research Coordinator

Karen Abou-Samra, RN, CCRC
Research Coordinator

Janell DeGiorgio
Research Coordinator

Rin Nelson
Research Coordinator

Liza Heap, BS, BA
Research Coordinator

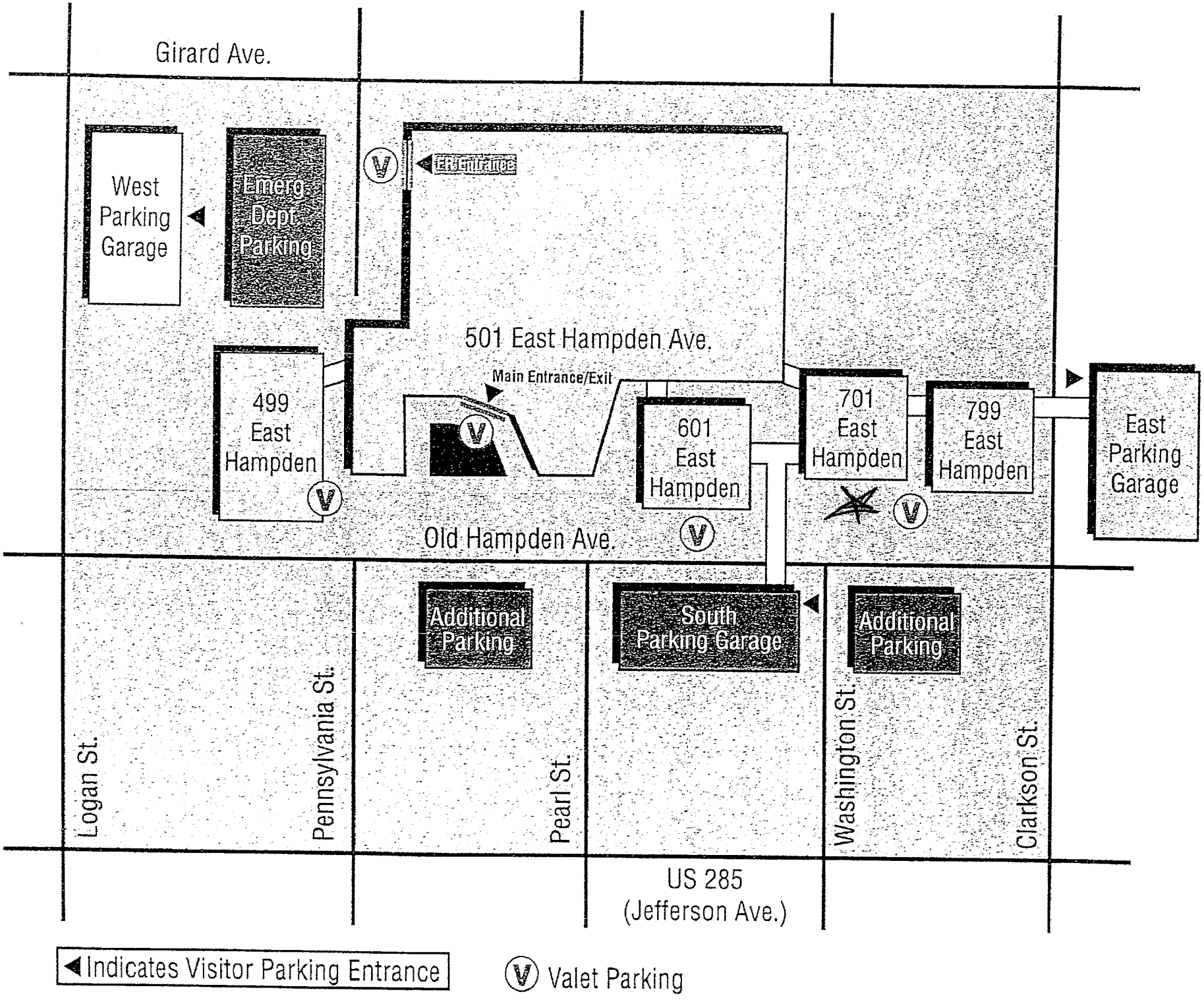
National Parkinson Foundation Care Center

NATIONAL PARKINSON FOUNDATION

Huntington's Disease Society of America Center of Excellence

Huntington's Disease Society of America

701 East Hampden Avenue
Suite 510
Englewood CO 80113-2759
(303) 357-5455 Phone
(303) 357-5459 Fax
www.movementdisorderscenter.org


Girard Ave.
West Parking Garage
Emerg Dept Parking
ER Entrance
501 East Hampden Ave.
Main Entrance/Exit
499 East Hampden
601 East Hampden
701 East Hampden
799 East Hampden
East Parking Garage
Old Hampden Ave.
Additional Parking
South Parking Garage
Additional Parking
Logan St.
Pennsylvania St.
Pearl St.
Washington St.
Clarkson St.
US 285 (Jefferson Ave.)
◀ Indicates Visitor Parking Entrance
Valet Parking