Welcome to Mount Nittany Physician Group

Thank you for trusting Mount Nittany Physician Group to care for you. We look forward to becoming your lifelong partner in health and wellness.

Enclosed are new patient forms to complete along with some helpful information for future reference. **Please complete the forms and bring them to your first appointment.**

You may also mail or drop off your completed forms before your appointment.

Please arrive 15 minutes before your appointment, so that we have time to review your information.

Please call us at 844.278.4600 if you have questions or concerns.

Thank you. We look forward to meeting you soon!

Contents:

HELPFUL INFORMATION

Patient-centered care

Mount Nittany Physician Group-Primary Care wants to be your partner in healthcare by serving as your medical home. It is our goal to provide you with a personal physician or provider who can deliver your healthcare needs and coordinate your care across all settings. Whether it is in the medical office, hospital, clinic, testing facility, or any other place you receive care, Mount Nittany Physician Group-Primary Care will be here for you.

- Our patient-centered medical home model places you at the center of your care team.
- Your primary care provider coordinates your care throughout all healthcare settings.
- Our medical home approach focuses on improving and maintaining healthy lifestyles through evidence-based care.
- Our team works with you to provide needed care and meet your personal health goals.

Care coordination

Mount Nittany Physician Group-Primary Care **requests your help** so we can provide you with the most efficient and effective care possible. To help us maintain a complete record of your care, please complete the following forms (enclosed) and bring with you to your visit with us:

1. Medical records release form*
2. Health history forms

Note: We also encourage you to inform your primary care provider of any care you received from a healthcare provider outside of your primary care home office.

*Any questions regarding completion of the form or transfer of your records can be directed to a front desk staff member who will be happy to help you.

Obtaining care/clinical advice

Mount Nittany Physician Group–Primary Care strives to meet your needs by offering early morning and extended hours. For the most up to date office hours by location, please visit our website at **mountnittany.org/physician-group/locations**.

Making appointments

- Patients may call 844-278-4600 or call your providers office directly to request appointments during normal business hours.

Clinical Advice

- A provider is available by phone after normal business hours and on weekends. Simply call your provider office, or call 844-278-4600 and an operator will connect you to an appropriate provider.
- For non-urgent advice, you may sign up for the online patient portal at mymountnittanyhealth.com at any time to request care and advice. Our patient portal allows you to request appointments, view your medical records and prescriptions and send questions to your provider.

EMERGENCIES: Call 911 if you feel you are having a life-threatening medical emergency.

For an URGENT but not life-threatening medical issue, please contact the office prior to going to any urgent care center or the emergency department for healthcare direction to help avoid unnecessary expense.

Appointment information

- We request that you give at least 24-hours notice if you are unable to keep a scheduled appointment.

- Patients that arrive more than 15 minutes late for an appointment may be asked to reschedule.

First appointment

- Please bring all of your current insurance identification cards. Please check to see that the cards are not expired.
- Please bring a valid photo identification card.
- Please bring a completed Medical Records Release Form
- Please bring a completed Patient History Questionnaire, including the medication list

Insurance information

- Our practice participates with a number of insurance plans. Please check the website, **mountnittany.org** for an updated list.
- We submit all insurance claims for you and bill the deductible, coinsurance, and non-covered balances directly to you upon receipt of the explanation of benefits from your insurance. These balances are due upon receipt of the statement from our office.
- If you have questions concerning your insurance coverage, please call your insurance carrier or our billing service at 800.762.9800.
- It is necessary for you to bring any co-payment(s) you will owe, according to your insurance benefits, to your office visit; it will be collected upon check in.
- We accept cash, checks, money orders, traveler's checks, Visa, Mastercard, Discover and American Express.
- If you do not have insurance or we do not participate with your insurance, please call 814.278.4820 and ask to speak to our collection specialist to discuss payment options.

Weather and holiday closings

Occasionally, this office will close due to weather conditions or holidays. Our voicemail system will notify you of availability or direct you to contact the answering service. You can also check mountnittany.org for office closing notifications.

Note: In the case of hazardous weather, one of our physicians will be on call. Please call the answering service at 814.231.5505.

Prescription refills

Monitor your medication carefully so that you do not run the risk of running out. When you need a refill for an existing medication, we ask that you contact your pharmacy or mail order service and they will contact us directly as needed.

It is important to know that NO CONTROLLED SUBSTANCE prescription refills will be made during times when the office is closed.

Laboratory and diagnostic testing

You may have your laboratory and diagnostic testing services performed at a facility of your choice. However, we encourage you to use Mount Nittany Health System facilities to expedite the transfer of information into your electronic health record. Please see mountnittany.org for a list of locations.

Referrals

All referrals to specialist providers are available after 48 hour notice with approval of your primary care physician. Please try to call our office to allow enough time to get the referral to the specialist office in a timely manner.

My Mount Nittany Health

My Mount Nittany Health is Mount Nittany Health's online patient portal, which includes the following features, among others:

1. Request appointments with your provider.
2. View your medical record including lab and diagnostic results, prescriptions and vaccinations.
3. Send questions about your appointments to your provider's office right from your computer.

If you're a parent, you can also request appointments and view medical records for your children using your own My Mount Nittany Health account. To learn more, visit MyMountNittanyHealth.com

Education resources

More than 3,000 health and wellness topics, HealthSheets and Health Break articles are available online at Mount Nittany Health's Wellness Library, available 24 hours a day at mountnittany.org/wellness-library.

Interpreter services

Interpreters for foreign languages and the hearing impaired are available free of charge. Please let your nurse know if you need communication assistance.

Mount Nittany Physician Group locations

Mount Nittany Health – Bellefonte
129 & 141 Medical Park Lane
Bellefonte, PA 16823
Internal Medicine: 814.355.7322
Pediatrics: 814.355.3626

Mount Nittany Health –
Blue Course Drive
1700 Old Gatesburg Road, Suite 310
State College, PA 16801
Internal Medicine: 814.237.3122

Mount Nittany Health – Boalsburg
3901 S. Atherton Street
State College, PA 16801
ENT/Audiology: 814.466.6396
Pediatrics: 814.466.7921
Pulmonary Medicine: 814.231.7888

Mount Nittany Health –
Green Tech Drive
2520 Green Tech Drive
State College, PA 16803
Internal Medicine: 814.278.4898

Mount Nittany Health –
Green Tech Drive
2505 Green Tech Drive, Suite A1
State College, PA 16803
Dermatology: 814.237.6600

Mount Nittany Health – Mifflin County
96 Kish Road
Reedsville, PA 17084
Cardiology: 855.689.7391
Family Medicine: 855.259.0027
General Surgery: 800.837.6062
Occupational Health: 814.231.7094
Urology: 800.837.6062

Mount Nittany Health – Park Avenue
1850 E. Park Avenue
State College, PA 16803
Cardiology: 814.689.3140
Endocrinology: 814.689.3156
Heart Failure Clinic: 814.689.3140
Internal Medicine: 814.234.8800
Medicine Specialties: 814.234.8800
OB/GYN: 814.237.3470
Occupational Health: 814.231.7094

Mount Nittany Health - Penns Valley
4570 Penns Valley Road
Spring Mills, PA 16875
Family Medicine: 814.422.8873

Mount Nittany Health -
Sieg Neuroscience Center
2121 Old Gatesburg Road, Suite 100
State College, PA 16803
Neurology: 814.231.6868
Sleep Management Program:
814.231.7277

Mount Nittany Health –
University Drive
905 University Drive
State College, PA 16801
Urology: 814.238.8418
Surgery: 814.238.8418

Mount Nittany Physician Group -
Reconstructive &
Cosmetic Surgery
100 Radnor Road, Suite 101
State College, PA 16801
814.231.7878

Patient Label

MOUNT NITTANY HEALTH

Authorization for Release/Request of Protected Health Information Mount Nittany Health

MR#:_____ Acct #:_____

I hereby authorize **Mount Nittany Health,** consisting of Mount Nittany Medical Center (MNMC) and Mount Nittany Physician Group (MNPG), to release or request my health information:

Patient Information: Name: _____Date of Birth: _____

Address: _____

Telephone: _____ E-mail: _____

Release Information To: Name:_____

Address: : _____

Telephone: _____ Fax: _____E-mail: _____

Request Information From: Name:_____

Address: : _____

Telephone: _____ Fax: _____E-mail: _____

The information to be released or requested shall be *limited* to the following:
Location of service (check all that apply): ☐ MNMC ☐ MNPG (specific office if needed):_____

Dates of service: _____

☐ Medical Record (complete)
☐ Consultation Reports
☐ Discharge Summary
☐ Safety Plan
☐ Pertinent MNMC (H&P, Consultation, Operative, Pathology, Diagnostic)
☐ Pertinent MNPG (Office notes, labs, procedures)
☐ ED Mental Health Evaluation & Liaison Note _____
☐ History and Physical (H&P)
☐ Laboratory Test Results
☐ Operative Reports
☐ Office notes
☐ X-Ray, Imaging Reports
☐ ED Records
☐ Discharge Instructions
☐ Progress Notes
☐ Medication List
☐ Other (specify):_____

The purpose of the disclosure is as follows: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: _____

I authorize this information be released or requested in the following manner (check all that apply):
☐ Pick up ☐ Mail ☐ CD ☐ Fax: _____
☐ E-mail:_____ ☐ Verbal – Behavioral Health Staff Only

I understand that this release may also include (Check to approve release of):

☐ Information relating to AIDS or HIV infection

☐ Information relating to mental health or psychiatric care continuing care plan and/or treatment for substance and/or alcohol abuse or dependency: excludes Psychotherapy notes

The confidentiality of my records may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. To the extent I have checked any of the above boxes; my signature below authorizes the release of information protected by these Pennsylvania statutes.

White – Medical Record

Patient Label

MOUNT NITTANY HEALTH

Authorization for Release/Request of Protected Health Information Mount Nittany Health

MR#:_____ Acct #:_____

NOTICE OF DISCLOSURE

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from MNH unless the only purpose for providing you with a service is to obtain information to disclose to someone else (e.g. examinations required to obtain certain licenses). If the services are related to research, you may be required to authorize the use or disclosure of your health information limited and related to the research services.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Finally, I understand that I am entitled to obtain a copy of this authorization from the Mount Nittany Health upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED; OTHERWISE, AND UNLESS IT IS REVOKED EARLIER.

_____

Signature of Patient or Patient Representative | Print Name | Date | Time

_____

Witness Signature | Date | Time | Witness Signature | Date | Time

If Patient is unable to give consent or if a Verbal consent is given, two MNH employees must sign as Witnesses.

If signed by Patient Representative, state relationship and authority to do so: (check all that apply)

☐ Parent of Minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Custodial Parent
☐ Legal Guardian ☐ Executor of Estate of Deceased ☐ Authorized Legal Representative
☐ Power of Attorney for Health Care ☐ Other: _____

☐ Revoked_____ _____ _____
Patient or Patient Representative | Date | Time

Office Use Only:

Photo ID Obtained: Y / N
Driver's License #:_____
Other:_____
Records Released on:_____
Records Released by:_____
Number of pages:_____

Received by:_____Date:_____Time:_____
Transmitted by:_____Date:_____Time:_____

White – Medical Record

PATIENT INFORMATION SHEET

Patient information:

Name:_____

Patient #:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Birth date:_____ **Age:**_____

Home phone number:_____

Work phone number:_____

Cell phone number: _____

Social security number (SSN):_____

Employer (if workers compensation):_____

Primary care doctor: _____

Primary care doctor's city and state: _____

Previous name: _____

Patient nickname: _____

College student status (full-time, part-time or none): _____

Email: _____

Marital status: _____

Guarantor information (if patient is under 18 or incapacitated):

Guarantor name: _____

Home phone number: _____

Work phone number:_____

Cell phone number: _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Sex:_____

Date of birth: _____

Emergency contact:

Contact name: _____

Relationship:_____

Emergency phone number:_____

May the emergency contact have access to your protected health information? ___Yes ____No

Other contacts (Your personal contacts that may have acess to your protected health information):

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Patient Information Sheet (continued)

	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Name				
Policy/Certificate #				
Group #				
Group Name				
Subscriber Name				
Subscriber Date of Birth				
Co-payments				

Insurance Information:

Payment: I understand that I am responsible for reimbursement of services not covered by my insurance. I authorize payment of my insurance benefits directly to Mount Nittany Physician Group (MNPG).

Privacy: I am aware that a copy of MNPG Notice of Privacy Practices is available upon request. I give permission for the persons(s) designated above to access my protected health information (e.g., obtain my test results, schedule, verify and cancel my appointments; discuss my healthcare with my physician and his/her assistants)

Diagnostic Facilities Choice: I understand that I may choose the facility where I have my diagnostic testing done. I am not limited to using MNPG facilities. I understand that there are other medical laboratories and radiology facilities located in the State College Area.

Please acknowledge and agree to these terms by signing below.

Patient signature: _____

Date: _____

MOUNT NITTANY PHYSICIAN GROUP

Pediatric Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Pharmacy
Retail: _____
Mail Order:_____

Preferred Method of Reminder Communication
I would like to receive reminder communication via:
☐Patient portal ☐Cell phone ☐Home phone
☐Mail ☐Work phone

Other than needing glasses or contacts, does the parent/guardian have any visual impairment affecting reading? ☐Yes☐No
Does the parent/guardian have any vision/hearing impairment? ☐ YES☐ NO
Explain: _____

HEALTH CARE TEAM: Please list other health care providers that your child may see (example: Cardiologist)

Name	Specialty

Child's birth weight (if under 1 year old) _____lb. _____oz

ACTIVE PROBLEMS/PAST MEDICAL HISTORY
Does your child currently have any of the following medical problems? Place "X" in **ACTIVE** Problem column.
Has your child had any of the following medical problems in the past? Place "X" in **PAST** Problem column.

	Active Problem	Past Problem		Active Problem	Past Problem		Active Problem	Past Problem
Acid Reflux	☐	☐	**Depression**	☐	☐	**Hyperthyroidism**	☐	☐
Anemia	☐	☐	**Developmental Delay**	☐	☐	**Hypothyroidism**	☐	☐
Anxiety	☐	☐	**Diabetes**	☐	☐	**Learning disability**	☐	☐
Arthritis	☐	☐	**Digestive Problem**	☐	☐	**Neuromuscular Disorder**	☐	☐
Asthma	☐	☐	**Eating Disorder**	☐	☐	**Overweight**	☐	☐
Autism Spectrum	☐	☐	**Genetic Disorder**	☐	NA	**Prematurity** Weeks gestation_____	☐	☐
Bleeding Disorder	☐	☐	**Head Injury**	☐	☐	**Seizure**	☐	☐
Breech Birth	NA	☐	**Headaches**	☐	☐	**Skin disorder**	☐	☐
Cancer _____	☐	☐	**Hearing Difficulty**	☐	☐	**Tuberculosis**	☐	☐
Childhood Behavior Problems	☐	☐	**Hospitalized** (1+ nights other than routine normal newborn stay)	NA	☐	**Urinary Tract Infection**	☐	☐
Congenital Heart Defect	☐	☐	**History of ear infections**	☐	☐	**Vision Problem**	☐	☐
Cystic Fibrosis	☐	NA	**Hyperlipidemia** (High cholesterol)	☐	☐			
Dental Cavities	☐	☐	**Hypertension** (High Blood Pressure)	☐	☐			

Has your child had any other serious medical problems not listed previously? ☐ YES ☐ NO
If YES, please list: _____

Created 8/11/15
Revised 01/19/16, 3/7/16, 3/17/2016

Patient Name: _____Date of Birth: _____

PAST SURGICAL HISTORY

☐ *No history of prior surgery

Has your child had any of the following surgical procedures, ***include year if known:***

Adenoids removed ☐ Yes ☐ No Year_____ Elective Circumcision ☐ Yes ☐ No Year_____

Appendix removed ☐ Yes ☐ No Year_____ Hernia repair ☐ Yes ☐ No Year_____

Ear Tubes Inserted ☐ Yes ☐ No Year_____ Tonsils removed ☐ Yes ☐ No Year_____

List any other ***operations or surgeries*** your child has ever had, ***including year if known***:

Type of Surgery	Year

FAMILY HISTORY

Is there any of the following in your child's immediate family? Check all that apply

☐ Patient is Adopted

	Mother	Father	Brother	Sister	Other:
Family History Unknown	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Cancer					
• _____	☐	☐	☐	☐	☐
• _____	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Hip Dysplasia	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Died from heart disease before age 50	☐	☐	☐	☐	☐
Sudden Infant Death Syndrome	NA	NA	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Patient Name: _____Date of Birth: _____

Immunizations: We require a copy of your child's immunization record.

SOCIAL HISTORY

For children under age 5, who primarily watches your child during the day? Check all that apply:

☐Parent/Guardian ☐Daycare Center/Home Daycare ☐ Grandparent or other relative ☐ Babysitter

☐Other: _____

Dental Care

*Does your child have a dental checkup at least yearly? ☐YES ☐NO

Living Situation: Select which best describes your child's living situation. Check all that apply.

☐ Lives in group home ☐ Lives with father (single parent) ☐ Lives with foster parents ☐ Lives with friend ☐ Lives with grandparent(s) ☐ Lives with mother (single parent)	☐ Lives with parents in same household ☐ Lives with parents who live in different households ☐ Lives with relatives ☐ Other: _____

Does anyone that lives in the home smoke either inside or outside the home? ☐Yes ☐No

ALLERGIES

Does your child have any allergies? ☐YES ☐NO

If YES, please list:

Name	Type of Reaction

Please List all MEDICATIONS your child is presently taking. Please include prescriptions, over the counter, vitamins, herbal and/or other supplements:

Name of Medication	**Strength (Ex 50 mg)**	**Directions (Ex. 1 pill twice daily)**	**Why do you take this medication?**	**Who prescribed this medication?**
ONLY COMPLETE THIS SECTION IF YOUR CHILD IS A NEW PATIENT				

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____

Patient Name: _____ Date of Birth: _____

PLEASE HAVE THE PATIENT WHO IS 13 AND OLDER COMPLETE THIS PAGE

Smoking History (Check one):

☐ Current smoker How many cigarettes per day? _____
☐ Former smoker When did you quit? _____
☐ Never a smoker
☐ Other _____

Smokeless Tobacco History (Check one):

☐ Never used smokeless tobacco
☐ Former user of smokeless tobacco When did you quit? _____
☐ Smokeless tobacco use What type of smokeless tobacco? _____

Alcohol Usage (check one):

☐ Alcohol Use
☐ No Alcohol Use

Illicit Drug Use–(check one):

☐ Current drug use
☐ History of drug use
☐ No drug use What types of drugs? _____

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____

Partnering with you for your best health

We will:

Share information about your health in a way that you understand

- We listen to your concerns and discuss your diagnosis in words you can understand. We outline a plan of care. We discuss medicine changes, doses, and important side effects. We also explain procedures and tests, highlighting their benefits and possible complications. We review all test results with you so that you understand what they mean. We do our best to meet your medical, physical, and emotional needs.
- We have interpreters for many languages and for the hearing impaired to help you during healthcare discussions. This is a free service. Please let our staff know if you need an interpreter.

Offer choices about your care including what should be done and what should not be done

- Our team works with you and any other people you want to include to achieve your best health. If you see more than one provider, we make sure they are all aware of your unique healthcare needs. We work together to make your care between providers smooth and stress-free.
- We follow the highest ethical standards by telling you about the risks, benefits, and alternatives to treatments.

Tell you about any financial ties we have with drug and medical companies

Treat you with respect, including the right to privacy and confidentiality

- We treat all patients with kindness and dignity. We respect cultural, religious, and personal beliefs.
- We do our best to be timely, attentive, and patient focused. Our providers keep personal information, business matters, and complaints in strict confidence. We follow the highest standards of professional behavior at all times.

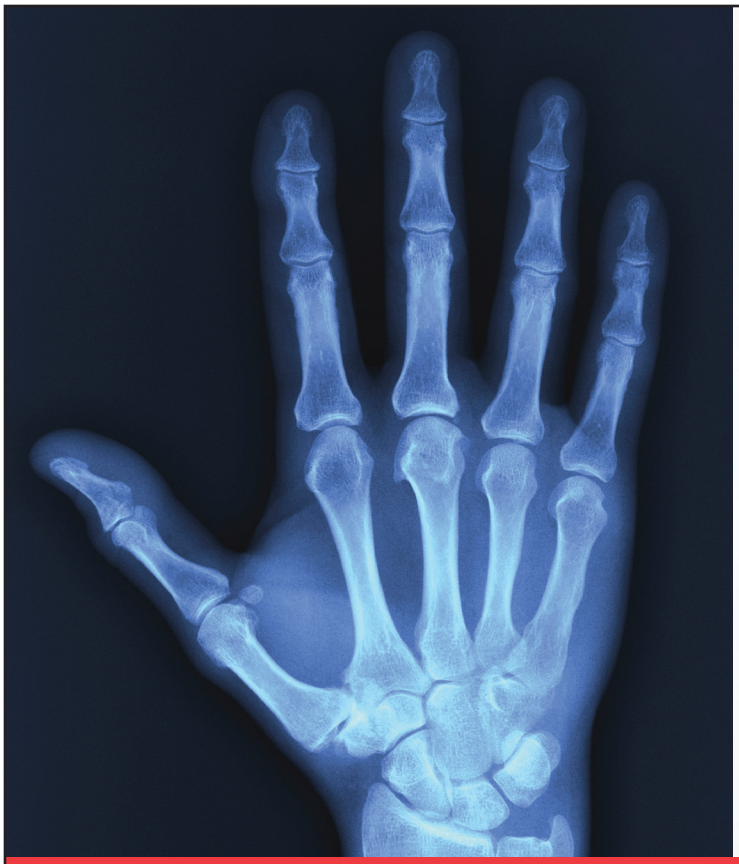
Provide compassionate, safe, quality care delivered by skilled staff, including doctors, physician assistants, nurses, and other members of our team

- We do our best to provide healthcare that is safe, effective, and patient-centered. We practice evidence based medicine and follow the latest clinical guidelines. We continually review, measure, and improve our patient care processes.
- Our providers attain board certification, as well as state and national licensures, and attend medical education programs to make sure that the latest in training, treatment, and technology are available for the community. Our partnerships with higher education help to make sure that the next generation of healthcare providers is informed, compassionate, and community-focused.

We ask that you:

- Give true and complete information
- Be an involved and informed member of your healthcare team
- Follow plans of care that you agree on with your healthcare team, which includes taking medicines and keeping appointments
- Pay promptly for the healthcare that you receive
- Respect the rights of other patients, families, and staff

If you have a concern or need, please talk to your doctor, nurse, or the office manager. In most cases, we can resolve the matter quickly and effectively. If your matter needs more attention, please call the Service Excellence department at 814.234.6706.



We have many lab and imaging locations for your convenience

Mount Nittany Health - Blue Course Drive
1700 Old Gatesburg Road | Suite 100
State College, PA

Imaging — 814.234.6106
MRI: Monday - Friday, 7:30 am - 5:30 pm
Ultrasound: Monday - Friday, 7:30 am - 3:45
X-Ray/fluoroscopy: Monday - Friday, 8:30 am - 5:00 pm

Lab — 814.231.6876
Monday - Friday, 7:30 am - 3:45 pm;
Saturday, 7:30 am - 12:30 pm

Mount Nittany Health - Boalsburg
3901 S. Atherton St. | State College, PA

Imaging — 814.466.7927
X-Ray: Monday - Friday, 8:30 am - 11:30 am

Mount Nittany Health - Bellefonte
141 Medical Park Lane | Bellefonte, PA

Lab — 814.355.7322
Monday - Friday, 7:30 am - 4:00 pm

Mount Nittany Health - Mifflin County
96 Kish Road | Reedsville, PA

Lab — 855.259.0027
Monday - Friday, 7:00 am - 5:00 pm

Mount Nittany Health - Park Avenue
1850 E. Park Avenue | State College, PA

Imaging (Suite 105) — 814.234.6752
MRI: Monday & Wednesday, 8:00 am - 3:30 pm
Digital mammography: Monday - Friday, 6:30 am - 5:00 pm
Open until 6:00 pm on Wednesdays
Bone Density: Monday - Thursday, 8:00 am - 4:30 pm
Closed Fridays

Imaging (Suite 203) — 814.234.6137
X-ray: Monday through Friday, 8:30 am to 5:00 pm

Lab (Suite 205) — 814.231.6848
Monday - Friday, 7:00 am - 5:30 pm.

Mount Nittany Health - Penns Valley
3631 Penns Valley Road | Spring Mills, PA

Lab — 814.422.0559
Monday - Friday, 7:30 am - 4:30 pm;
Saturday, 8:00 am - noon

Imaging — 814.234.6137
X-Ray: Monday through Friday, 8:00 am to 4:30 pm

MOUNT NITTANY® HEALTH