IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JOYCE BECHTOLD, P.T.A.	*	**STATE BOARD OF**
LICENSE NO.: A1762	*	**PHYSICAL THERAPY EXAMINERS**
Respondent	*	**CASE NUMBER: PT 11-44**

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CONSENT ORDER

The State Board of Physical Therapy Examiners (the "Board") charged **JOYCE BECHTOLD, P.T.A., LICENSE NO. A1762 (the "Respondent") (D.O.B. 9/26/61)**, with violating the Maryland Physical Therapy Act (the "Act") codified at Md. Health Occ. Code Ann. § 13-101, *et seq.*, ("the Act") (2009 Repl. Vol. and 2012 Supp.).

Specifically, the Board charges the Respondent with violating the following provisions of H.O. § 13-316:

> **13-316. Denials, reprimands, probations, suspensions and revocations-Grounds**
>
> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:
>
> (5) In the case of an individual who is authorized to practice limited physical therapy is grossly negligent:
>
> (i) Practices physical therapy other than as authorized by this title;
>
> (11) Practices physical therapy or limited physical therapy with an unauthorized person or supervises or aids an unauthorized person in the practice of physical therapy or limited physical therapy;
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> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;

(14) Submits a false statement to collect a fee;

(15) Violates any provision of this title or rule or regulation adopted by the Board;

(19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy;

(20) Grossly overutilizes health care services[.]

The pertinent provisions of the Code of Maryland Regulations ("COMAR") referred to, *infra,* in §13-316(15) provides the following:

COMAR 10.38.02.01 Code of Ethics

F. The physical therapist and physical therapist assistant shall report to the Board of Physical Therapy Examiners all information that indicates a person is allegedly performing, or aiding and abetting, the illegal or unsafe practice of physical therapy.

COMAR 10.38.03.02 Standards of Practice.

B. Physical Therapist Assistants

(1) The physical therapist assistant shall:

(a) Follow the direction and plan of care of the physical therapist in the treatment of the patient;

(d) Use only methods and procedures within the scope of the practice of limited physical therapy;

(f) Work within the physical therapist assistant's competency in treatment that is within the scope of practice of limited physical therapy;

(g) Document ongoing communication regarding changes in a patient's status and treatment authorized by the physical therapist

(2) The physical therapist assistant may:

(a) Enter into an agreement or employment relationship provided that the agreement or relationship does not impede the physical therapist assistant's exercise of appropriate patient treatment or cause the physical therapist assistant to practice limited physical therapy in violation of the Maryland Physical Therapy Act[.]

(3) The physical therapist assistant may not initiate treatment until:

(a) The patient has been evaluated and the plan of care has been developed by a physical therapist[.]

COMAR 10.38.03.02-1 Requirements for Documentation.

C. The physical therapist assistant shall document the patient's chart each time that patient is seen by the physical therapist assistant following the physical therapist's initial evaluation or reevaluation by including the following:

(1) Date;

(2) Cancellations and no-shows;

(3) Modalities, procedures, or both including parameters involved, and areas of body treated;

(4) Objective status;

(5) Response to treatment if any;

(6) Continuation of plan as established by the physical therapist or change of plan of care as authorized by the physical therapist; and

(7) Signature, title (PTA) and license number, although the flow chart may be initialed.

E. Ongoing Communications. Both the physical therapist and the physical therapist assistant shall document ongoing communication between the physical therapist and physical therapist assistant regarding changes in a patient's status and treatment plan.

On or about February 19, 2013, the Respondent appeared before the Case Resolution Conference Committee (the "CRC") of the Board in order to attempt to resolve the Charges against her. The Respondent agreed to enter into this Consent Order as a full and final resolution of the Charges.

FINDINGS OF FACT

The Board finds the following:

Background

1. On or about August 22, 1994, the Respondent was initially licensed to practice limited physical therapy as a physical therapist assistant ("P.T.A") in the State of Maryland. Her license will expire on May 31, 2014.

2. In or around August 29, 2005, the Respondent and Owner A established Integrated Therapy, LLC ("Integrated"), a private health care practice. The Respondent maintained an equity interest in Integrated from January 1, 2006-December 31, 2006, when she sold her interest to Owner A. At all times relevant, the Respondent was listed as the resident agent for Integrated.

3. From January 1, 2006 to December 31, 2006, the Respondent served in the capacity of co-owner, independent contractor, and clinical director of Integrated. Following the sale of her equity interest, she served as an independent contractor, resident agent and intermittent clinical director.

4. Beginning in 2008, Owner A and the Respondent entered into an intimate, personal relationship. That relationship ended in early 2011.

5. On or about April 11, 2011, the Board received an anonymous complaint alleging that the Respondent, as a licensed P.T.A., had knowledge that Owner A was practicing physical therapy ("P.T.") without a license and billing P.T. services under her name and license number. It was further alleged that the Respondent was in an intimate relationship with Owner A and had participated in the submission of fraudulent bills to patients and their insurers.

6. Thereafter, the Board initiated an investigation during which the identity of the anonymous complainant ("the complainant") was discovered.

7. The results of the Board's investigation are set forth, *infra*.

I. BOARD INVESTIGATION

8. On or about April 28, 2011, Board staff interviewed the complainant, a licensed health care provider and former patient of Integrated. The complainant stated that she was treated approximately 89 times from June 6, 2008 to September 10, 2010. In response to a subpoena, the complainant also produced copies of treatment and billing records.

9. The Board's investigation revealed that the complainant was first evaluated by a physical therapist ("Therapist A") for cervicalgia and postural dysfunction on June 10, 2008. She was subsequently treated by Owner A for all but four (4) visits. The Respondent treated her on at least two (2) occasions.

10. On July 18, 2008, the Respondent casted orthotics for the complainant. This treatment was neither in the original plan of care nor was it supervised by Therapist A. Although more than thirty (30) days had passed since the initial evaluation, no reevaluation had been performed or documented. The Respondent, however, proceeded to treat the complainant, without the benefit of a reevaluation or an updated, documented plan of care.

11. On twenty seven (27) additional visits, Integrated's bills listed the Respondent as the treating "physical therapist" and billed for services under her license number. There were no treatment notes for any of the visits billed, and no 30-day reevaluations were performed or documented.

12. The Respondent documented that she next treated the complainant more than one (1) year later on or about July 24, 2009. At that time, she performed ultrasound without any supervision or written direction from Therapist A. Integrated's billing statement

listed Therapist A as the provider on that date, and charged for therapeutic exercise, neuromuscular re-education, manual therapy and massage.

13. During the 2 ½ year course of the complainant's treatment, the Respondent attended weekly office meetings with Owner A and Therapist A during which they discussed patients including the complainant. The Respondent knew or should have known that Owner A was performing P.T. and billing under her license number. It is undisputed that she was aware that Owner A was not documenting his treatment.

14. The complainant estimated that she and/or her insurer[1] paid Integrated in excess of $9,000 for P.T. treatment. A large percentage of that amount was attributable to P.T. performed by Owner A and billed under the Respondent's license number.

15. The Respondent failed to report this unauthorized practice to the Board.

16. In furtherance of its investigation, the Board subpoenaed twenty-five (25) patient records[2] and other relevant documents. The Board also conducted interviews of three (3) other patients, which corroborated the information alleged in the complaint.

Patient A[3]

17. Patient A, a 51 year-old female, was treated at Integrated from October 26, 2010- March 25, 2011. Therapist A performed an initial evaluation, concluding that the patient suffered from cervicalgia and neurofibroma with left side facial nerve paralysis. Therapist A was required to perform re-evaluations every thirty (30) days, on or about December 26, 2010, January 26, 2010, or February 26, 2010, respectively. The only re-evaluation was performed on March 4, 2011, shortly before discharge.

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[1] Although unclear from the medical records, it appears that patients paid Integrated directly and would later submit bills to their insurance companies. The bills referenced CPT codes reserved for P.T. treatment only.
[2] Owner A failed to produce all of the subpoenaed records claiming that he had misplaced or destroyed several patient files. The Respondent failed to produce records stating that she did not maintain possession or control over the patient records.
[3] Patient A was interviewed by Board staff on or about November 3, 2011.

18. The Respondent treated Patient A on at least eleven (11) occasions from November 2, 2010 through March 31, 2011, but failed to adequately document any ongoing communication between her and Therapist A. Further, she treated Patient A without the benefit of written supervision, 30 day re-evaluations or an updated plan of care.

19. The Respondent knew or should have known that Owner A was also providing ongoing P.T. to Patient A, including therapeutic exercise and neuromuscular stimulation and mobilization, and that he was not documenting that treatment in the medical record. Further, based on weekly office meetings, the Respondent had constructive knowledge that Owner A was billing his treatment under Therapist A's license number. In fact, the billing records reveal that all treatment provided to Patient A was falsely billed under Therapist A's license number.

Patient B[4]

20. Patient B, a 49 year-old male, was a patient of Integrated for approximately five (5) years from 2006 to 2011. His most recent treatment, beginning on or about December 29, 2010 and ending on or about April 5, 2011, focused on back and hip pain resulting from an injury.

21. The Respondent first treated Patient B at his first visit on December 29, 2010. No initial evaluation had been performed by Therapist A or any other physical therapist at Integrated. The Respondent advised Patient B that his hip was out of joint and initiated treatment without a plan of care. Without supervision, with the assistance of an acupuncturist also employed by Integrated, the Respondent rotated Patient B's hip into place. She then treated him with electrical stimulation but failed to document any treatment rendered.

[4] Patient B was interviewed by Board staff on or about December 16, 2011

22. The following day, on December 30, 2010, the Respondent referred Patient B to an orthopedist for an MRI and cortisone shot. Although the Board's investigation indicated that she also sold him a TENS[5] unit, billing him $382.00 for the unit and two (2) prior office visits, the Respondent disputed that finding. The Board's investigation revealed that Therapist A had not authorized or supervised in writing any treatment rendered and had no knowledge of the Respondent's prescribing and sale of the TENS unit.

23. The Respondent treated Patient B on at least six (6) occasions between December 29, 2010 and his discharge on April 5, 2011, but failed to adequately document her treatment or any ongoing communication with Therapist A. Further, she treated Patient B without the benefit of an initial evaluation, written continuing supervision, 30 day re-evaluations or an updated plan of care.

24. The Respondent should have known that Owner A was also providing ongoing P.T. to Patient B, including therapeutic exercise and neuromuscular stimulation and mobilization, and that he was not documenting that treatment in the medical record. Further, based on weekly office meetings, the Respondent had actual or constructive knowledge that Owner A was billing his treatment under Therapist A's license number. In fact, the billing records reveal that all treatment provided to Patient B was billed under Therapist A's license number.

Patient C[6]

25. Patient C, a 27 year-old female, was a patient of Integrated for approximately four (4) years from June 24, 2007 through April 6, 2011, following a diagnosis of Lyme disease. Her most recent treatment regimen began on or around

[5] Trancutaneous Electrical Nerve Stimulation is the use of electric current produced by a device to stimulate nerves in order to break nerve-related pain cycles.
[6] Patient C was interviewed by Board staff on January 10, 2011.

February 12, 2010 when she presented with back pain, fatigue and limited tolerance to standing or sitting. She was initially treated by Therapist A, but no initial evaluation or plan of care was documented in the medical chart.

26. Patient C was treated by Integrated on approximately forty-nine (49) occasions. For the vast majority of visits, the billing record was the sole source of information documenting that a visit had taken place. Although the Respondent treated Patient C on at least two (2) occasions, the bills reflected that all treatment was provided by Therapist A.

27. The Respondent failed to adequately document her treatment or any ongoing communication with Therapist A. Further, she treated Patient C without the benefit of a documented initial evaluation, continuing written supervision, 30 day re-evaluations or an updated plan of care.

28. The Respondent knew or should have known that Owner A was also providing ongoing P.T. to Patient A, including therapeutic exercise and neuromuscular stimulation and mobilization, and that he was not documenting that treatment in the medical record. Further, based on weekly office meetings, the Respondent had actual or constructive knowledge that Owner A was billing his treatment under Therapist A's license number.

The Respondent

29. On or about March 6, 2012, Board staff interviewed the Respondent. By letter dated March 22, 2012, legal counsel for the Respondent provided supplemental information to that interview.

30. The Respondent stated that she and Owner A established Integrated, as a limited liability corporation ("LLC") on August 29, 2005. From January 1, 2006 to

December 31, 2006, she served as co-owner and resident agent of the LLC. Effective January 1, 2007, the Respondent relinquished her equity interest to Owner A and assumed the role of independent contractor. From January 1, 2006 to April 14, 2011, the Respondent was listed as the resident agent for the LLC.

31. On or about January 1, 2007, the Respondent entered into an independent contractor agreement to provide health care services to Integrated, individually and/or through her wholly owned business, SCS therapies.

32. The Respondent was aware that Owner A did not hold a P.T. license in Maryland. It was her understanding that Owner A had a "national" massage therapy license and that his expertise was limited to *Reiki*, a form of energy work similar to manual therapy. She stated that most patients were initially evaluated by the Therapist A and subsequently became either *Reiki* patients or continuing P.T. patients.

33. The Respondent admitted that initial evaluations and re-evaluations were not performed in a timely manner and sometimes not at all. She conceded that without a proper and timely re-evaluation, P.T. should not have been initiated or continued. The Respondent stated that she simply followed verbal directions and instructions given by Therapist A and that she advised Therapist A that re-evaluations were overdue.

34. The Respondent stated that she routinely spoke with Therapist A at weekly office meetings but failed to document those communications in the patients' medical records. She also admitted that she failed to maintain adequate and/or timely records of treatment or updated plan of care recommendations made by Therapist A.

35. The Board's investigation revealed that the Respondent was aware that Owner A was providing treatment to mutual patients and was failing to document his treatment. The Respondent was non-responsive when asked direct questions about the

nature of Owner's A's treatment, how that treatment was billed and who was responsible for the billing. She did, however, concede that Owner A treated patients designated as "P.T. patients" on the office schedule and that bills were typically predetermined by the office staff.

36. The Respondent admitted to delegating her billing responsibilities to office staff. She understood that all treatment was billed under the same CPT codes irrespective of the patients' presenting symptoms, subsequent progress, respective health care provider or treatment modalities utilized. She further conceded that at some point, Therapist A's name and license number was used on all patient bills, even for services provided by the Respondent and/or Owner A. This was because "they kept asking for the supervising therapist's name. So [Therapist A's] name was put on".

37. The Respondent also had a discussion with Therapist A questioning the appropriateness of providing patients with a "superbill" for *Reiki* treatment, presumably submitted as P.T. treatment under the name and license number of Therapist A. The Respondent, however, failed to report this suspected billing discrepancy to the Board or bring it to the attention of Owner A.

Therapist A

38. On or about March 7, 2012, Board staff interviewed Therapist A. She stated that she had been employed with Integrated from 2006 to 2011. As part of her responsibilities, Therapist A agreed to provide professional oversight and supervision to the Respondent.

39. Throughout the course of her employment, Therapist A believed that Owner A held a valid license to practice massage therapy in the State of Maryland. At no time did she believe that Owner A held a valid license to practice P.T.

40. Therapist A admitted that since leaving her employment with Owner A, she realized that "maybe some things were not quite the way they should have been, run the right way[.]" She further stated that she was aware that the Respondent failed to adequately or timely document treatment provided to patients and that Owner A maintained no documentation of his treatment. She did not attempt to address these issues with Owner A or the Respondent, or report these violations of the Act to the Board.

41. Therapist A stated that Owner A provided cranial sacral therapy to patients, a form of manual therapy performed by physical therapists and massage therapists. At times, Therapist A co-treated patients with Owner A and knew that insurers would not typically reimburse massage therapists for manual therapy but would reimburse a physical therapist for similar treatment. She claimed that she was unaware of the billing procedures and did not review the bills submitted to patients or insurers.

42. Therapist A further stated that Integrated charged each patient the same amount for each treatment session, that bills were duplicates of one another and that the same modalities of treatment were provided irrespective of the presenting symptoms or injury. Therapist A knew or should have known that patients were consistently charged for P.T treatment performed by others under her name and license number.

43. Therapist A admitted that she did not perform re-evaluations every thirty (30) days as required and that Owner A and the Respondent treated patients without the benefit of re-evaluations.

44. Therapist A failed to provide consistent supervision to Respondent and acknowledged that at times, Respondent exceeded the scope of her duties as a physical therapy assistant. Therapist A stated that she did not authorize Respondent to perform

treatment that exceeded the scope of her practice including but not limited to casting of orthotics, ultrasound or prescribing of a TENS unit.

Board Expert

45. On or about April 25, 2012, the Board retained an expert consultant ("Board expert") to review relevant patient and billing records as well as interview transcripts. In addition to reviewing the records and transcripts of Patients A-C, the Board expert also reviewed sixteen (16) patient records produced by Owner A/Integrated responsive to the Board's subpoena(s).

46. The Board expert issued a report on or about May 21, 2012. In that report, the Board expert summarized the Respondent's care and treatment of each patient and further provided expert opinions, to a reasonable degree of medical probability, as to numerous deficiencies in that care.

47. The Board expert opined that the Respondent, as original co-owner and clinical director of Integrated, practiced limited P.T. with an unauthorized person, Owner A, and that she co-treated patients knowing that he was not a licensed physical therapist. By failing to report his unlicensed practice and fraudulent billing to the Board, the Board expert opined that the Respondent acted unprofessionally and violated the applicable Code of Ethics.

48. The Board expert concluded that the Respondent knew that Owner A and Integrated submitted bills under her name and license number and that these bills constituted false reports, records and bills for services not rendered by a licensed physical therapist.

49. With respect to at least two (2) patients, the Board expert found that the Respondent over-utilized health care services.

50. The Respondent further practiced unauthorized P.T. by casting orthotics and prescribing care not directed by her supervising physical therapist.

51. The Board expert concluded that with respect to at least three (3) patients, the Respondent breached the standards of practice by initiating treatment prior to an initial evaluation and/or plan of care developed by a licensed physical therapist. For at least six (6) patients, the Respondent also continued treatment without the benefit of updated plans of care or 30 day re-evaluations. The Respondent failed to report these violations of the Act to the Board and provided no rationale for her failure to do so.

52. The Board expert found that the Respondent failed to adequately and/or timely document the patients' charts regarding her treatment and/or ongoing communication with Therapist A.

II. SUMMARY

53. The Board's investigation revealed that the Respondent practiced limited physical therapy with an unlicensed individual and failed to report obvious violations of the Act to the Board. She violated the Code of Ethics and acted in an unprofessional manner.

54. The Respondent was grossly negligent and breached the standards of practice by utilizing treatment modalities not authorized under the Act. She also exceeded the scope of limited physical therapy and worked outside of her competency.

55. The Respondent failed to maintain adequate or timely documentation each time she saw a patient and further failed to document ongoing communications with Therapist A.

56. The Respondent entered into an intimate, personal relationship that compromised her objectivity and impacted her ability to practice limited physical therapy in compliance with the Act.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated H.O. § 13-316 (5) In the case of an individual who is authorized to practice limited physical therapy is grossly negligent: (i) Practices physical therapy other than as authorized by this title; (11) Practices physical therapy or limited physical therapy with an unauthorized person or supervises or aids an unauthorized person in the practice of physical therapy or limited physical therapy; (14) Submits a false statement to collect a fee; (15) Violates any provision of this title or rule or regulation adopted by the Board; and (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy[.] The Respondent's actions further constitute violations of COMAR 10.38.02.01F - Code of Ethics; 10.38.03.02B(1)(a),(d),(f),and(g), B(2)(a) and B(3)(a) - Standards of Practice and 10.38.03.02-1C(1-7) and E-Requirements for Documentation.

The Board dismisses the Charges under H.O. § 13-316 (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy; and (20) Grossly overutilizes health care services.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 21st day of May 2013, by a majority of a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice physical therapy shall be **SUSPENDED** for a period of **SIX (6) MONTHS,** with all but **FORTY FIVE (45) DAYS STAYED;** and it is further

ORDERED that the Respondent's license to practice physical therapy shall be placed on probation for a period of **THREE (3) YEARS,** to commence from the date that this Consent Order is executed, subject to the following conditions:

1. Within six (6) months of the date of this Consent Order, the Respondent shall take a closed book Maryland Jurisprudence Examination and achieve a pass rate of 85 % or higher.

2. Within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in billing and CPT coding;

3. Within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in documentation;

4. The Respondent shall be subject to a chart audit by the Board each year of probation consisting of at least five (5) patient records to assess the Respondent's scope pf practice, documentation and billing practices. The Respondent shall implement corrective measures that address deficiencies in the chart review process;

5. Within six (6) months of the date of this Consent Order, the Respondent shall pay a fine in the amount of $5,000, payable to the Board; and

6. The Respondent shall provide to the Board documentation of satisfactory completion of all probationary conditions and terms.

ORDERED that the Continuing Education requirements required by this Consent Order shall not count toward fulfilling other continuing education requirements that the Respondent must fulfill in order to renew her license to practice physical therapy; and be it further

ORDERED that the Respondent shall practice according to the Maryland Physical Therapy Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of physical therapy; and be it further

ORDERED that at the conclusion of the **THREE (3) YEAR probationary period**, the Respondent may file a written petition for termination of probationary status without

further conditions or restrictions. The Board, in its discretion, may consider whether there are outstanding complaints, investigations or Charges pending against the Respondent.

ORDERED that should the Respondent violate any terms or conditions of this Consent Order, the Board, after notice, opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including reprimand, probation, suspension, revocation or a monetary fine, said violation being proven by a preponderance of the evidence, and be it further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (2009 Repl. Vol. and 2012 Supp.).

ORDERED that, for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. §10-617(h) (Repl. Vol. 2009 and 2012 Supp.), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order, and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

05/21/13
Date

John Baker, P.T., DSc. P.T. Chair
Board of Physical Therapy Examiners

CONSENT OF JOYCE BECHTOLD, P.T.A.

I, Joyce Bechtold, P.T., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by the foregoing Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce the Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

5/2/13
Date

Joyce Bechtold
Joyce Bechtold, P.T.A.
Respondent

Read and approved by:

Carolyn Jacobs
Carolyn Jacobs, Esq., Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Howard :

I HEREBY CERTIFY that on this 2nd day of May, 2013, before me, a Notary Public of the foregoing State personally appeared Joyce Becthtold P.T.A. License Number A1762, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Public

My Commission Expires: 5/29/2016

SARAH CHUN
Notary Public
Howard County
Maryland
My Commission Expires May 29, 2016