Beth Israel Deaconess HealthCare℠
Pastor Medical Group

Joseph Raduazzo, MD
Medical Director

Jayson Carr, MD
Joycelyn Datu, MD
Bruce Pastor, MD
Debbie Shlain, MD
Alla Tandetnik, MD

1180 Beacon Street
8th Floor
Brookline, MA 02446

617-734-2433 Phone
617-277-9821 Fax

Dear Patient:

On behalf of all of us at Beth Israel Deaconess HealthCare-*Pastor Medical Group*, we want to welcome you to our practice.

It is important to us that your transition into our practice be as smooth as possible. Therefore, we have put together the following information for you and hope you find it helpful. If you have any questions, please give us a call at 617-734-2433.

ABOUT OUR MEDICAL STAFF

Our practice is staffed with 6 board-certified internists providing comprehensive care in Internal Medicine. They are all members of the faculty of Harvard Medical School and maintain admitting privileges at Beth Israel Deaconess Medical Center in Boston.

HOURS OF OPERATION AND WAYS TO CONTACT OUR OFFICE

Our regular hours of operation are Monday through Friday 8:00am – 5:00pm. Our office strives to have convenient access for each patient. Please contact us by the method that is most convenient for you.

Telephone: 617-734-2433
Fax: 617-277-9821
Email: https://www.patientsite.org/

AT YOUR FIRST APPOINTMENT PLEASE BRING THE FOLLOWING:

- Health insurance card and copayment (both are required at every visit)
- Completed registration forms and legal form of ID
- List of all medications you are taking
- List of any prescriptions that you need filled
- Medical records from previous physicians, if available.

Once care has been established with your primary care physician, it is our policy not to allow patients to switch to another provider in the practice.

Patients that do not show or cancel with less than 24 hours of notice will be assessed a $50 fee.

INSURANCE

Our practice accepts most types of insurance, managed care plans, indemnity plans, as well as Medicare and Tufts Together with BIDCO. We ask that you familiarize yourself with your health insurance policy, especially regarding referrals to specialists, emergency care, and preventive care. If you request a service that your insurance plan does not cover, you will be responsible for payment at the time of your visit.

If you have a HMO or Managed Care plan, you must call your insurance company prior to your first appointment to list your new primary care physician.

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EMERGENCY CARE

A physician is on-call for emergencies 24 hours a day. If there is an emergency or an urgent matter that needs to be addressed, please call the office and our answering service will page the physician on-call. In a life threatening situation, call 911 to activate emergency services.

URGENT CARE

If you need urgent care, please call us in advance to schedule an appointment. We try to see every patient who needs an evaluation within 24 hours. For urgent care, most of the time, your primary care physician will see you but if he or she is not available, another physician in our practice may see you.

LAB RESULTS

Your physician will inform you of your results in writing or verbally within two weeks. They also may be obtained online once you register with PatientSite, the patient portal. The address is https://www.patientsite.org . If results warrant immediate action, your physician will contact you by phone. Unless your physician directs you to do so, we ask that you do not call the practice for your results.

PRESCRIPTION REFILLS

All refills for prescriptions must be requested in writing, by mail, by email via https://www.patientsite.org, or faxed from your pharmacy. The prescription refill is then faxed directly back to the pharmacy unless you request it to be mailed to your home.
NOTE: Please allow 3 days for refill requests to allow our practice and the pharmacy time to process the prescription.

REFERRALS

When your primary care physician determines that you need to see a specialist, you will be referred to a Beth Israel Deaconess specialist. We strongly recommend that you become familiar with the details of your health insurance plan, particularly regarding what services are covered by your policy. When you have scheduled an appointment with a specialist, you must notify our referral department at least seven (7) business days prior to your scheduled appointment by emailing them through PatientSite (https://www.patientsite.org) or by calling 617-754-0550.

BILLING

Our billing is done through Medical Care of Boston. If you have a billing question, please contact them directly at 617-754-0730 or askapg@bidmc.harvard.edu.

We continue to strive for excellence in our patient care and satisfaction and look forward to a long and healthy relationship with you.

Sincerely,

Beth Israel Deaconess HealthCare- *Pastor Medical Group*

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Pastor Medical Group

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8th Floor
Brookline, MA 02446

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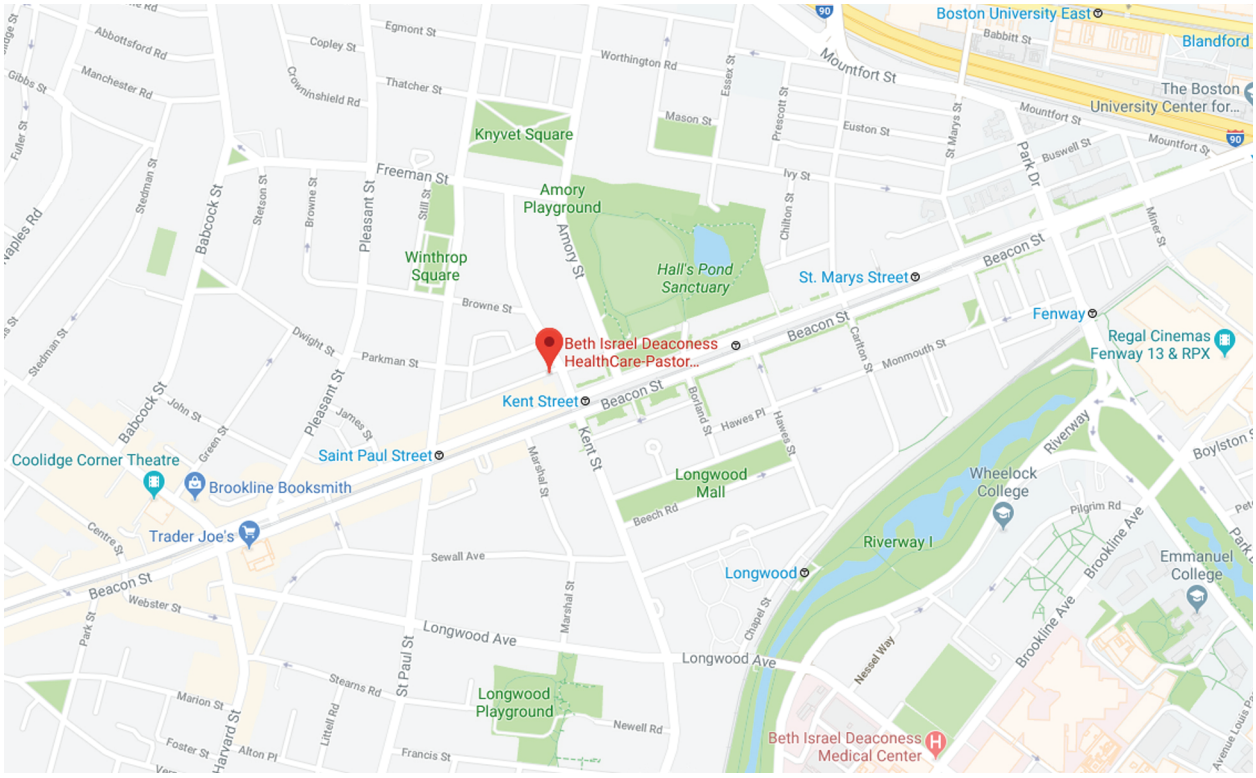
Directions to Beth Israel Deaconess HealthCare-*Pastor Medical Group*



Local Directions
Take Storrow Drive to the Kenmore Square exit. Take a right after the first light onto Beacon Street. BIDHC-*Pastor Medical Group* is about one mile on the right.

From Route 90/Mass Pike
Take exit 18 off the Mass Pike, stay right towards Cambridge. Make a right at the first light onto the Storrow Drive exit. Follow local directions above.

From North of Boston
Take route 93 south into Boston. Take exit 26 toward Storrow Drive and follow local directions above.

From South of Boston
Take route 95 until the highway splits then continue on 93 north towards Boston. Take exit 26 toward Storrow Drive and follow the local directions above.

From 128/Route 9
Take route 128 to route 9 east, exit 20 towards Brookline/Boston. Follow the route going past Chestnut Hill Mall. Take a left onto Chestnut Hill Avenue, immediately after the fire station on your left. Take a right onto Beacon Street. Follow Beacon Street for about 2 miles and the office will be on the left.

By MBTA
Take the C train on the Green Line to Kent Street stop (3 stops after Kenmore Square).

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Dear Patient,

Beth Israel Deaconess HealthCare-Pastor Medical Group and its predecessor, Fischbein Medical Associates, has enjoyed a very close working relationship with the Beth Israel Deaconess Medical Center since 1958. We still have a number of patients who have been served by our medical group since that time. As we continue to grow and expand, we appreciate the opportunity to serve so many wonderful patients as part of your health care team.

In the time we have been affiliated with the Beth Israel Deaconess (BID) system, we have grown to konw many excellent BID specialists. We look forward to serving your primary care needs at our current practice, and would like to ensure we are able to be involved in all aspectes of your care. Should you need specialty care outside of our primary care practice, we welcome the opportunity to help you choose the right specialists for your needs.

There are many important benefits of receiving well-coordinated care from our team of Beth Israel Deaconess specialists:

- A shared electronic medical record allows for up-to-date access of your medical information. Sharing of information has been proven to reduce unnecessary testing and medical costs.
- Improved communication and collaboration among your primary care doctor and specialists enhances the quality and coordination of your care.

Beth Israel Deaconess Medical Center (BIDMC) has been recognized for excellence in patient care. Here are some of the honors and achievements:

- BIDMC and its three member hospitals – Beth Israel Deaconess Hospital-Milton, Beth Israel Deaconess Hospital-Needham and Beth Israel Deaconess Hospital-Plymouth, received "A" grades in the Fall 2015 Hospital Safety Score, for their strength in keeping patients safe from preventable harm.
- A Harvard Medical School teaching hospital, BIDMC is known for pioneering medical discoveries and offering patients access to groundbreaking clinical trials.

For these reasons, we feel strongly that it is best for the care of our patients to coordinate care within the Beth Israel Deaconess system. Medicare patients are free to visit any health care provider who accepts Medicare.

As your primary care physicians, we are your health care advocates - the ones who personalize and coordinate your care with your specialist, and it is important that we can be involved in all aspects of your care. We invite you to talk to us about your needs - current or future - and would be happy to help make sure you have the right specialists - for you.

If you have any questions or comments, please let us know.

Sincerely,

Jayson Carr, MD, FACP
Joycelyn Datu, MD
Bruce Pastor, MD

Joseph Raduazzo, MD
Debbie Shlain-Frink, MD
Alla Tandetnik, MD

Beth Israel Deaconess Medical Center
Boston, MA 02215

GENERAL AGREEMENT

MR0446

General Information:

I request care from one or more of the following organizations, for treatment of my medical and/or mental health condition, and/or for the routine or intensive care of my child:

- Beth Israel Deaconess Medical Center (BIDMC)
- Harvard Medical Faculty Physicians at BIDMC (HMFP)
- Beth Israel Deaconess Healthcare (BID-Healthcare)

This care may include medical tests, exams, or treatments that are needed for my (my child's) condition.
I agree to this treatment and care.

Use and Disclosure of Medical Information:

BIDMC, HMFP, and BID-Healthcare may disclose to others and request from others my medical information. My information may be shared for treatment, healthcare operations, and payment purposes. Information shared may include information about my mental health or substance abuse treatment, but only the information necessary to coordinate my care.

- I agree to the sharing of my medical and mental health information for treatment, healthcare operations and payment purposes.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my mental health or substance abuse treatment with other providers to coordinate my care.
- I have the right to request a restriction or limitation on how my medical or mental health information is used or shared. I understand that these organizations may not be able to act on all of my requests.
- I have the right to take back my consent, in writing, except when my consent has already been acted upon.

Insurance and Payment Information:

BIDMC, HMFP, and BID-Healthcare receive payment from insurance companies, Medicare, and/or other third party programs.

- I agree to let my doctor(s) and/or BIDMC submit claims and treatment information to my insurance program (private insurance, Medicare, etc.) for payment and to evaluate the quality of care I receive.
- I agree to have my insurance program make payments directly to BIDMC, HMFP, and BID-Healthcare.
- I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance program.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my inpatient or outpatient mental health or substance abuse treatment with my insurance program for payment purposes.

Special Note about Mental Health Benefits:

I understand that if I am using my health insurance benefits to pay for mental health treatment, and/or substance abuse treatment, my insurance program may need some information from my clinician(s).

The information that insurance companies need for initial sessions of **outpatient** treatment is limited to diagnosis, and type of treatment. However, if my outpatient treatment is to go beyond those initial sessions, then my insurance company will need additional information. If I am going to receive mental healthcare as an outpatient, I understand that my insurance company may have limits on the number of visits that it will pay for. I need to stay informed of my plan's mental health benefits.

If I am going to receive mental health treatment as an **inpatient**, my insurer will request information from my clinicians about my hospitalization. This additional information allows my insurer to determine if the treatment is medically necessary and if payment for treatment will be authorized.

Please continue on the reverse side.

Beth Israel Deaconess Medical Center
Boston, MA 02215

GENERAL AGREEMENT

- continued -

Durable Medical Equipment: Durable Medical Equipment (DME) is medical equipment to be used outside the hospital and at home. Examples of DME include nebulizers, wheelchairs and blood pressure monitors. I understand that it is my responsibility to obtain any DME that my healthcare professional says that I need. I am responsible for any and all costs not covered by insurance.

Release of Liability for Retention of Valuables: I understand that it is not wise to keep personal valuables with me while I am in the Medical Center. I understand that the BIDMC staff is willing to keep my valuables safe by placing them in a secure location while I am in the Medical Center. I understand that if I keep my valuables with me, and they are either stolen or lost, BIDMC does not have any liability and they will not reimburse me for the item(s).

The Healthcare Team: Beth Israel Deaconess Medical Center is a teaching facility. I understand that treatment and care will be provided by a team of healthcare providers headed by a staff doctor. I understand that this healthcare team may include resident doctors, nurses, and clinical students / staff. These healthcare team members may also watch or take part in my treatment and care.

Instructions for Patients: Please sign sections **A** and **B**.

A. General Information: I have read this form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form.

X_____ _____ **OR**
Patient's Signature — Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ____/____/____ **Time:** ___ ___ : ___ ___ ○ a.m. ○ p.m.

B. Privacy Notice: I have received copies of the BIDMC "Notice of Privacy Practices" and "Your Rights and Responsibilities as a Patient". BIDMC has the right to change privacy practices. Any changes will be effective for medical information BIDMC already has about me as well as information BIDMC receives in the future. I am aware that I may request an additional or revised copy of "Notice of Privacy Practices".

X_____ _____ **OR**
Patient's Signature — Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ____/____/____ **Time:** ___ ___ : ___ ___ ○ a.m. ○ p.m.

Beth Israel Deaconess HealthCare™
An Affiliated Physicians Group Practice
Medical Care of Boston

PCP _____

Affiliated Physicians Group

❑ NEW PATIENT INFORMATION ❑ UPDATE FOR ESTABLISHED PATIENT

PATIENT INFORMATION

Name _____ Date of Birth _____

Street Address _____

City, State, Zip _____ E-mail Address _____

Home Phone _____ Work Phone _____ Other Phone _____

Social Security Number _____ Sex ❑ Male ❑ Female

Employer _____

Address _____

THE NEXT QUESTIONS ARE FOR IDENTIFICATION PURPOSES

Mother's first name _____ Father's first name _____

Your marital status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's first name (if applicable) _____ Maiden name _____

Religious Affiliation: (optional) _____ Race/Ethnic background: (optional) _____

Emergency Contact/Next of Kin Name _____ Relationship _____ Phone _____

Address _____

Employment status ❑ Full time ❑ Part time ❑ Self employeed ❑ Retired ❑ Unemployed

Occupation _____

Employer _____ Address _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Policy # _____ Group # _____ Plan # _____

Subscriber's Name **(if different than above)** _____

Relationship to Patient _____ Soc. Sec. # _____

Subscriber's Address _____

Subscriber's Phone # _____ Subscriber's Employer _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Policy # _____ Group # _____ Plan # _____

Subscriber's Name **(if different than above)** _____

Relationship to Patient _____ Soc. Sec. # _____

Subscriber's Address _____

Subscriber's Phone # _____ Subscriber's Employer _____

Please help us care for you better by letting us know where you heard about us.

❑ Family/Friend
❑ Insurance Book
❑ Newspaper
❑ Mailing
❑ Television
❑ Radio
❑ Telephone Book/Directory Assistance
❑ Health Information Line (B.I. Deaconess Telephone Referral Service)
❑ Attended B.I. Deaconess Educational/Screening Event
❑ Other _____

Practice Copy

Medical Care of Boston Management Corporation

Authorization and Insurance Waiver Form

Authorization to pay insurance benefits:

I hereby direct my insurance carrier to pay Medical Care of Boston Management Corporation (MCB) physician insurance benefits otherwise payable to me.

Signature **Date**

If you are a Member of a Managed Care Plan:

I understand that I have an obligation to get a referral for specialty service from Primary Care Physician prior to making an appointment. If a referral is not received by my specialist, I understand that I may be responsible for full payment of services received should this be deemed by my health plan.

Signature **Date**

Authorization for Release of Information:

I hereby authorize Medical Care of Boston Management Corporation (MCB) to release billing and medical record to my insurance carrier and legal representative for medical services rendered to me by the physicians of MCB.

Signature **Date**

MEDICAL HISTORY

NAME:			DATE:
DATE OF BIRTH:	MARITAL STATUS:	NUMBER OF CHILDREN:	OCCUPATION:

EDUCATION (Highest Level Attended):

PLEASE LIST ALL MEDICATIONS AND DOSAGES:

ALLERGIES

MEDICATIONS:

OTHER:

DATE OF LAST EXAM:	PHYSICIAN:

PRIOR HOSPITALIZATIONS AND OPERATIONS:

DATES:	PROBLEMS:

DO YOU USE TOBACCO? _____YES _____NO

IF YES, PLEASE SPECIFY PACKS PER DAY AND YEARS SMOKED

IF NO, PLEASE SPECIFY ANY HISTORY OF SMOKING AND DATE STOPPED

DO YOU USE ALCOHOLIC BEVERAGES? _____YES _____NO

TYPE:

WEEKLY AMOUNT:

ONSET OF LAST MENSTRUAL PERIOD:	PERIODS ARE: _____REGULAR ____IRREGULAR	NUMBER OF PREGNANCIES:
DATE OF LAST MAMMOGRAM:	DATE OF LAST PAP SMEAR:	ORAL CONTRACEPTIVES: _____YES _____NO

FAMILY HISTORY OF ILLNESS

	AGE:		STATE OF HEALTH - PRINCIPAL ILLNESS
	ALIVE	DECEASED	
FATHER			
MOTHER			
SIBLINGS			

Beth Israel Deaconess HealthCare®

Patient Financial Responsibility Guidelines

Beth Israel Deaconess HealthCare (BIDHC) is pleased you have chosen our practice for your medical care. Quality care is a first priority among our providers. To reduce confusion and keep costs of your care to a minimum, BIDHC requests that you please read the following guidelines to understand your financial responsibility and requirements.

Patients with Health Insurance

- Please bring your insurance card to each visit so that the office staff can verify your eligibility.
- Not all services may be covered by your insurance plan therefore the obligation to understand what services are covered remains with you. Please contact your insurance carrier regarding covered services.
- If your insurance requires a referral to see one of our MDs for specialty care, please contact your PCP's office. The referral will need to be in place prior to your visit.

Co-Payments

- Co-payments will be expected on each date of service when required by your insurance.
- Please understand co-payments may be required when problems are addressed during your annual physical visit.
- If you have questions regarding your co-pay amount, please call your health plan directly.

Worker's Compensation (WC) / Motor Vehicle Accident (MVA) Visits

- Please inform both the scheduling and check-in staff that your visit is due to either a work-related injury or a motor vehicle accident.
- WC and MVA insurance carriers require related forms to be filled out in order for reimbursement of your claims to occur. Please bring your employer, worker's compensation, auto insurance carrier and/or attorney information to your office visit.
- Patients will be billed directly if the above information requested is not provided to our offices.

Establish PCP with your Health Insurance

- If your health insurance requires the selection of a primary care physician (PCP), please make sure this is in place prior to your appointment.
- Patients may be responsible for the visit if the PCP has not been established with your health plan.

Self-Pay Patients

- A deposit for services provided in the physician office is expected at the time of your visit. Any remaining balance will be billed to you.

No Shows

- We require 24 hour cancellation notice if you are unable to keep your appointment.
- Please understand that you may be charged a no show fee for missed appointments.

Billing Questions

We realize that special circumstances may arise and will assist you in every way we can to resolve your outstanding balances. Financial hardship discounts are available. To apply please contact our Billing department.

Please understand we reserve the right to transfer delinquent accounts to a collection agency after all efforts have been exhausted to obtain payment from you.

Statements sent to you from BIDHC are for the physician's portion of the visit. Hospital, laboratory and radiology services may be billed to you separately from those facilities. Please call them directly when bill questions arise.

Please feel free to contact our Billing department with any questions at **(617) 754-0730** between the hours of **8:00am-4:00pm, Mon – Fri** or email askapg@bidmc.harvard.edu at your convenience.

X ***Patient Signature***_____***Date:*** _____

I acknowledge receipt of these patient financial responsibility guidelines.

Beth Israel Deaconess HealthCare®

Patient Representative Authorization Form

By filling out this form I am giving permission to Beth Israel Deaconess HealthCare (BIDHC) to talk to the person(s) listed as my patient representative about my past, present, and future health information. I understand my health information may include general health information such as appointment times and medications as well as sensitive information such as testing and/or treatment of communicable disease, HIV/AIDS, drug and alcohol abuse, and behavioral/mental health matters. I also understand that it is my responsibility to tell my representative(s) if I give them permission to share the information they receive with others. If they do share the information with others, those actions may not be protected under federal and/or state law.

I understand my permission given to BIDHC does not expire until I cancel or change it. Cancellation or changes to my permission may be made at any time and must be made in writing and sent to my Primary Care Physician's office. I understand that cancellation or changes will not apply to information already communicated to my representatives. I also understand that cancellation or changes will not begin until my written request is received by my Primary Care Physician's office. If I want to change my representative(s), I must complete a new form. I understand that when I fill out a new form, my previous form is no longer valid.

I voluntarily give my permission to BIDHC to talk to my representative(s). I do not need to sign this form to assure treatment. If I have questions about the disclosure of my health information, I understand that I can contact the BIDHC Compliance Office at (617) 754-0541.

My Information (Patient)

Name:_____ Date of Birth: _____

Street:_____

City: _____ State: _____ Zip: _____

Patient Representative(s): Please list individuals you want to be your representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure he/she has this information.

1. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____
2. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____
3. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____

I understand by signing below I give permission to BIDHC to talk to my representative(s) listed above about my health information without restrictions.

Patient Signature: _____ **Date:**___/___/_____ **Time:**_____ **o a.m.** **o p.m.**

Print Name: _____

If signed by legal representative, relationship to patient: _____