Beth Israel Deaconess HealthCare®
Newton Centre

Nancy Cooper, MD
Kari Emsbo, MD
Yana Urman, MD

714 Beacon Street
Newton Centre, MA 02459

617-332-1001 Phone
617-332-5154 Fax

Dear Patient:

On behalf of all of us at Beth Israel Deaconess HealthCare-*Newton Centre*, 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 617-332-1001.

For your first appointment it is important to arrive 15 minutes early so that staff will have time to set up your medical record prior to see the physician.

ABOUT OUR MEDICAL STAFF

Our practice is staffed with 3 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. We are also affiliated with Beth Israel Deaconess Hospital-Needham, Beth Israel Deaconess Hospital-Milton and Beth Israel Deaconess Hospital-Plymouth.

HOURS OF OPERATION AND WAYS TO CONTACT OUR OFFICE

Our regular hours of operation are Monday through Friday 8:00am – 5:30pm. Our office strives to have convenient access for each patient. Please contact us by the method that is most convenient for you.

Address: 714 Beacon Street, Newton Centre, MA, 02459
Telephone: 617-332-1001
Fax: 617-332-5154
Email: https://www.mysite.bidhc.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 should be forwarded prior to your initial visit.

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 Mass Health. We ask that you familiarize yourself with your health insurance policy, especially regarding referrals to specialists, emergency care, and preventative 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 MySite, the patient portal. The address is https://www.mysite.bidhc.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.mysite.bidhc.org, or faxed from your pharmacy. The prescription refill is then faxed directly back to the pharmacy unless it requires it be picked up in office. 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 calling 617-754-0560.

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- *Newton Centre*

Beth Israel Deaconess HealthCare℠

Patient Information

Name _____ Date of Birth _____

Street Address _____

City, State, ZIP _____ E-mail _____

Primary Phone _____ (home/cell) Secondary Phone _____(home/cell)

SSN (optional) _____ Sex □ Male □ Female

Employment status □full time □part-time □self-employed □Retired □Unemployed

Employer _____

Address _____

Emergency Contact/Next of Kin

Name_____ Relationship _____ Phone _____

Information for Identification Purposes

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

Your marital status □ single □ married □ divorced □ separated □ widowed □other _____

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

Have you ever served in the U.S. Military? □ Yes □ No

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**

Beth Israel Deaconess HealthCare℠

Dear Patient:

Your visit today is scheduled as an "Annual Wellness Visit" or "Annual Physical", and does not require a co-payment under the *Patient Protection and Affordable Care Act*.

For your convenience, your physician or provider may treat you for a medical condition during your Annual Wellness Visit or Annual Physical today. This saves you from having to make several trips to our office.

As a result, **a co-payment or deductible** may be required by your insurance company if discussions beyond your preventive care occur. Some examples of this are as follows:

- Your physician needs to change your medication or orders tests to deal with PRE-EXISTING chronic problems, and /or
- Your physician treats you for any NEW problems you are currently experiencing.

For questions related to your benefit coverage and co-payments, please reach out directly to your insurance company. Our physician offices collaborate with many health insurance carriers and do not know what benefits you may qualify for under your particular plan.

I have read the above and understand that I may owe a co-pay if medically necessary services are provided during my Annual Wellness Visit or Annual Physical.

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

Patient MRN _____ (Office Use)

Thank you for taking the time to read and acknowledge this information. Please let us know if you would like a copy of this notification.

Beth Israel Deaconess HealthCare

Dear Patient,

Welcome to Beth Israel Deaconess Health Care Newton Centre.

If you are scheduled for a physical exam today, will you be addressing new and/or existing problems during that visit? (If so, a co-pay and/or deductible may be collected at the end of your visit).

Yes No

Please tell us your main health concerns today:

_____
_____
_____
_____
_____
_____
_____

Please understand that we will make every effort to address the concerns that are most important to you and your health. If we are not able to address all of your concerns today, we will ask that you make a follow-up appointment with one of our providers.

Thank you,

Staff of Beth Israel Deaconess Health Care Newton Centre.

List of *current* medical problems

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medication List

Please list all the medications you take currently taking and include dosage and instructions.
Please include all over the counter medications and herbal medicines

Medication Name	**Dosage**	**Instructions**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you had a:	Yes	No	Unsure	If Yes, when? (approx date)	If Yes, where? (what facility or doctor)
- flu shot this season?	☐	☐	☐		
- tetanus shot?	☐	☐	☐		
- colonoscopy before?	☐	☐	☐		
- mammogram? (females only)	☐	☐	☐		
- pap smear? (females only)	☐	☐	☐		
- shingles shot? (age ≥ 50)	☐	☐	☐		
- pneumonia shot? (age ≥ 65)	☐	☐	☐		

Allergies

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Care Team

Specialty	**Name of Provider**
Cardiology	1.
Ophthalmology	2.
Sports Medicine (Ortho)	3.
Pulmonology	4.
Endocrinology	5.
Rheumatology	6.
Gastroenterology	7.
Physical Therapy	8.
Otorhinolaryngology (ENT)	9.
Oncology	10.
Gynecology	11.
Psychiatry (Behavioral Health)	12.
Dermatology	13.
Urology	14.

Family History

Mother	Alive / Deceased	At Age	Problems:
Father	Alive / Deceased	At Age	Problems:
Maternal Grandmother	Alive / Deceased	At Age	Problems:
Maternal Grandfather	Alive / Deceased	At Age	Problems:
Paternal Grandmother	Alive / Deceased	At Age	Problems:
Paternal Grandfather	Alive / Deceased	At Age	Problems:
Siblings	Alive / Deceased	At Age	Problems:
Other:	Alive / Deceased	At Age	Problems:

Social History

As your primary care physician, we feel it is important to know about your lifestyle and habits that could influence your health and assess your health risk factors.

Smoking Status: ( ) Never smoker
( ) Former smoker
If so how long?____
( ) Current every day smoker
( ) Current some day smoker
( ) Smoker – current status unknown
( ) Unknown if ever smoked

Diet: ( ) Regular
( ) Vegetarian
( ) Vegan
( ) Gluten free
( ) Specific
( ) Carbohydrate
( ) Cardiac
( ) Diabetic

Tobacco-years of use: _____

Smoking - How much? ( ) None
( ) 1 Pack Per Week
( ) 2 Pack Per Week
( ) 1/4 Pack Per Day
( ) 1/2 Pack Per Day
( ) 1 Pack Per Day
( ) 1 1/2 Pack Per Day
( ) 2 Pack Per Day
( ) 3+ Pack Per Day

Exercise level: ( ) None
( ) Occasional
( ) Moderate
( ) Heavy

Fall Screen: ( ) No falls in the past year
( ) One fall in the past year without injury
( ) More than one fall or one fall with injury in the past year

Alcohol Intake: ( ) None
( ) Occasional
( ) Moderate
( ) Heavy

Fall Screen Date: _____

Advance Directive: ( ) Yes
( ) No

Drug Use: ( ) Yes
( ) No

Health Proxy Chosen: ( ) Yes
( ) No

Health Care Proxy Name: _____

Occupation: _____

Domestic Violence: ( ) None
( ) Current
( ) Past

Marital Status: ( ) Unknown
( ) Married
( ) Single
( ) Divorced
( ) Separated
( ) Divorced
( ) Windowed
( ) Domestic Partner

Education: ( ) Less than 8th grade
( ) 8th grade
( ) 9th grade
( ) 10th grade
( ) 11th grade
( ) 12th grade
( ) 2 Year College
( ) 4 Year College
( ) Post Graduate

Marital Status: ( )None

Number of Children: _____

Hobbies/Activities:_____

Live alone or with others: _____

Military Service: ( ) Yes
( ) No

Other: _____

Surgical History	Date

Depression screening:

Over the past 2 weeks, how often have you been bothered by any of the following problems:				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feel down, depressed, or hopeless	☐	☐	☐	☐

Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

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

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

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℠

464 Hillside Avenue
Needham, MA 02494

617-754-0700 Phone
617-754-0701 Fax

Dear Patient,

Welcome to Beth Israel Deaconess HealthCare and thank you for choosing us as your partner in primary care. Coordinating your specialty care is an important service that we provide and we may at times refer you to a specialist with expertise in a particular area. Our goal is to make sure you get the right care, at the right time and place. When specialty care is needed, we refer to our specialist colleagues within the Beth Israel Deaconess system. These are health care providers we know and trust.

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.

We look forward to working together to provide you with high quality primary care services and coordinating your specialty care.

Sincerely,

David Judge, MD
Chief Medical Officer
Beth Israel Deaconess HealthCare

Beth Israel Deaconess HealthCare™

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PERMISSION TO SHARE INFORMATION

A. Patient's Name (*please print*):	Date of Birth: ____ / ____ / ____ (month / day / year)	Medical Record Number (*if known*):
Address:	Telephone Number:	Social Security Number (*last 4 digits*):

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From / Between (Circle):	**To / Between** (Circle):
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
FAX Number: _____	FAX Number: _____
Telephone Number: _____	Telephone Number: _____

C. Reason for Release of Records: _____

D. Information to be released for treatment dates: From ____ /____ /____ through ____ /____ /____

E. Documents to be released: Please check YES or NO for each of the following options

YES	NO		YES	NO	
☐	☐	**Medical Records Abstract** (i.e., History & Physical, Operative / Procedure Reports, Clinical / Office Notes, Discharge Summary, All Diagnostic Test results)	☐	☐	Radiology Reports
☐	☐	Progress Notes	☐	☐	Laboratory Reports
☐	☐	Discharge Summary	☐	☐	Pathology Reports
☐	☐	Photographs / Videos	☐	☐	Operative Notes
☐	☐	X-Rays / X-Ray Reports (please specify): _____	☐	☐	Entire Medical Record
					Other (please specify): _____

F. Privileged or Specifically Protected Information: Please check YES or NO for each of the following questions

YES	NO		YES	NO	
☐	☐	Alcohol or Drug Abuse Treatment	☐	☐	HIV / AIDS diagnosis and/or treatment: I specifically give permission to share information in my record about my HIV / AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70F.
☐	☐	Sexually Transmitted Diseases			
☐	☐	Domestic Violence Victim's Counseling			
☐	☐	Sexual Assault Victim's Counseling			
☐	☐	Communication between patient and Social Worker			
☐	☐	Psychiatric Health – mental health information including communication between a patient and a Psychiatrist, licensed Psychologist, and Psychiatric Clinical Nurse Specialist	☐	☐	Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70G.

G. I understand and agree that:

- The information which I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- I will be charged a fee for information that is sent directly to me
- I decline the opportunity to inspect or copy the information released
- I have received a copy of this authorization
- I may take back this authorization at any time by notifying the physician / hospital / clinic / organization from whom I am requesting this information, provided that the information has not already been released
- This authorization is voluntary
- My treatment will not be conditioned on the completion of this authorization.
- My questions about this authorization form have been answered

H. This authorization expires 12 months from the date it was signed OR as specified: ____ /____ /____
If not specified, this authorization will expire 12 months from the date it was received.

I. 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.

Distribution: White = Medical Record • Canary = Patient **[Directions: Please See the Reverse Side]**

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.