NORTHEAST
SURGERY CENTER
State-of-the-Art Care

www.nesurgery.com

Christine M. Hayes, M.D.
DERMATOLOGIC SURGERY
Helen A. Raynham, M.D., Ph.D.
DERMATOLOGIC SURGERY

Loreen A. Ali, M.D.
PLASTIC SURGERY
Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGERY

Welcome to our Practice!

Dear Patient:

Northeast Surgery Center is dedicated to providing our patients with the best care available. Enclosed please find patient information and release forms. Before your visit, please carefully read and complete these forms and bring them with you to your scheduled appointment. Please arrive 10-15 minutes prior to your appointment so that we can review your paperwork.

The packet includes:
Directions to our office
Patient Registration & Privacy Form
Financial Policy
Appointment Tips
New Patient Survey
Medical/Surgical History Form

For more information about our practice, please visit us at www.nesurgery.com. Our Website provides detailed information about our physicians and our services.

We participate with many insurance companies; however, it is your responsibility to check with your insurance company to ensure that we participate and whether or not a referral is required for your visit.

If you did not have your insurance card handy when you made your appointment, at your convenience and prior to your appointment, **please call our pre-registration staff at (978) 244-0076 between the hours of 11:00 a.m. and 8:00 p.m.** They will enter the specifics of your insurance information and assist you with ensuring that your referral (if required by your insurance company) is in place.

If for any reason, you are unable to make it to the scheduled appointment, it is imperative that you call us 24 hours in advance to cancel or reschedule so that we can offer your appointment to another patient. New patient "NO SHOW" visits will not be rescheduled.

If you would like to correspond with our office via email regarding your care and treatment, please sign up to our new Patient Gateway, **www.patientgateway.org**.

We look forward to seeing you!

The Physicians and Staff of Northeast Surgery Center

22 Mill Street, Suite 304
***Arlington**, MA 02476*
781.641.4900 Fx 781.641.4904

33 Village Square
***Chelmsford**, MA 01824*
978.244.0060 Fx 978.244.2522

49 Walnut Park, Bldg. 4
***Wellesley Hills**, MA 02481*
781.431.0060 Fx 781.431.0062

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Directions to our Chelmsford Office:
33 Village Square
Chelmsford, MA 01824
(978) 244-0060
(978) 244-2522
www.nesurgery.com

If you are using a GPS, please use the address of 16 Fletcher Street, Chelmsford, MA 01824 and it will bring you to 33 Village Square.

Traveling on I 495 North:
Take I 495 north to exit 33, (Route 4 Chelmsford). Take a right off of the exit onto North Road. Take your first left hand turn onto Fletcher Street and then a right into Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on I 495 South:
Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on Route 2 West:
Take Route 2 west to I 495 north exit 40B (Lowell/Lawrence). Follow I 495 north to exit 33 (Chelmsford/Bedford). Take a right off of the exit onto North Road. Turn left onto Fletcher Street (at the Eastern Bank) and then takes a right into the Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on Route 2 East:
Take Route 2 East to I 495 north exit 40B (Lowell/Lawrence). Follow I 495 north to exit 33 (Chelmsford/Bedford). Take a right off of the exit onto North Road. Turn left onto Fletcher Street (at the Eastern Bank) and then takes a right onto the Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on I93 North:
Take I 93 north to I 495 south exit 44B (Lowell). Follow I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on I93 South:
Take I 93 south to I 495 south exit 44B (Lowell). Follow I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is red and is number 33 Village Square.

Traveling on Route 128/95 North:
Take I 95/MA 128 north to Route 3 north exit 32A (Lowell/Nashua). Follow Route 3 north to exit 30C/495 south (Chelmsford/Marlborough). Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is red and is number 33 Village Square

Traveling on Route 128/95 South:
Take I 95/MA 128 south to Route 3 north exit 32A (Lowell/Nashua). Follow Route 3 north to exit 30C/495 south (Chelmsford/Marlborough). Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is red and is number 33 Village Square

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Form date: 11/03/2011

General Patient Information

Patient Name ______________ Date of Birth __________ Age ______

SSN ______________ Marital Status S M W D

Address ______________ Home Phone ______________

______________ Cell Phone ______________

Primary Care Physician ______________ Town ________ Phone ________

Specialist physician who referred you ______________ Town ________ Phone ________

Ethnicity ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Declined to state**

Language Spoken: ______________ ☐ **Declined to state**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian or Other Pacific Islander** ☐ **White**

Email Address: ______________

(to be used to communicate health events, practice news, cosmetic specials and events **only** generated by the practice administrator. Email addresses are kept securely within our practice management system only)

PHARMACY

Name: ______________

Address: ______________

City: ______________

Phone:

Emergency Contact Information

Contact name ______________ Relationship ______________

Home Phone ______________ Business Phone ______________

Cell Phone ______________

I hereby authorize and request my insurance company to pay Northeast Surgery Center directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment of the difference and if the service provided is considered a non-covered service; I will be responsible for payment of that service.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or related claim. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts assignment. I certify that this information is true and correct to the best of my knowledge.

New Patient Portal

The most secure way to communicate with our office regarding your care and treatment is to sign up for the Patient Gateway, a free service that allows you to: reach us, request Appointments, view lab results, set appointment reminders, and more! To set up an account: **www.patientgateway.org**

HIPAA PRIVACY INFORMATION Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________, have received and reviewed a copy of the privacy notice of the privacy practices at Northeast Surgery Center.

______________ Patient Signature ______________ Date

We will leave appointment reminders on the main contact phone number that you provided at the time of the appointment.

May we leave other medical information on/with

Home Answering machine ☐ Yes ☐ No

Office voicemail ☐ Yes ☐ No

Cell Phone voicemail ☐ Yes ☐ No

Authorization to discuss my appointments and Health information:

______________ Name ______________ Relationship

______________ Name ______________ Relationship

☐ I decline to give anyone permission to have access to my medical information ______________ (patient initials)

Responsible for the Balance

Although you may have health insurance coverage through another person, all billing/payment information will always be sent directly to you and will be your responsibility.

Patient Signature Date

Our Financial Policy

Thank you for choosing us as your surgical Provider. We ask that you **carefully read** and sign the following Financial Policy

****We require a copy of <u>All</u> insurance cards and ask that you present them at <u>Each</u> visit****

Participating Insurances

We participate with many insurance companies.
Co-pays are due at time of service. If a co-payment is not made at the time of service, a $5.00 service charge may be added.

Non-Copayment Plans

If your plan does not require a copay and we participate, you are responsible for any deductible and balances that your plan indicates on the explanation of benefits.

Non Participating Insurances and Self Pay

Payment in full is required at the time of service. As a courtesy, we will bill your insurance.

Returned Checks

There is a $25.00 fee on all returned checks.

For All Insurances

Please review your benefit listing summary that you received from your insurance company to understand your coverage

Missed Appointments

Please make every effort to cancel your office visit at least 24 hours in advance or a missed visit charge of $25.00 may be assessed to you.

Medical Record Copy Fee

There is a fee for medical record copies in certain specified circumstances of .75 cents per page.

Referral from Your PCP

If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your visit and present it when you check in for your appointment

Cosmetic Consultations

Our consultation fee is $125.00. We require that you provide a $50 non-refundable deposit at the time you schedule your appointment with the balance of $75.00 due on the day of your visit. Cosmetic procedures are treated as self pay. If you have surgery in the hospital setting, your consultation fee payment will be applied toward your cosmetic procedure fee.

Account Balances and Collection procedures

You are responsible for timely payment of your account. Northeast Surgery Center reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you will be required to pay reasonable attorneys fees and any expense or costs relating to the collection proceeding, including court costs

<u>Payment Methods</u> - Cash, checks, Mastercard or VISA accepted
For certain situations, we will accept credit card payment plans.

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Northeast Surgery Center to furnish information to insurance carriers concerning my illness and treatments.

I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by Public health law for copying of medical records will be immediately due and payable. In the event that my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

______________________________ Patient Signature

____________________ Date

______________________________ Patient Print Name

Parent/Guardian Print Name: ______________________________
Parent/Guardian Signature: ______________________________
Print Patient Name if Minor: ______________________________

(revised 07/21/10)

APPOINTMENT TIPS

Being organized and focused will help you get the most satisfaction and communication from your visit. Here are a few tips to help you prepare for the dialogue.

Before your appointment

Write down all of the questions you want to ask your physician that you think are the most important to you.

Things to bring with you for your visit

Please bring your completed new patient forms, your referral and a copy of your insurance card.

Bring a list of all your medications, both prescription and over the counter. Also, bring in a list of any herbs or supplements you may be taking. Bring your bottles if that is easier as we need to be aware of your dosages.

If you think you might feel uncomfortable or scared, bring a friend or relative who can help take notes and ask questions for you.

Before, and After Your Appointment

Prior to your appointment, a member of our Call Center staff will telephone you to confirm your appointment. If you should have a surgical procedure in our office, you can expect a phone call after your discharge to find out how you are doing and to gain some feedback regarding your experience here in our practice. We appreciate your feedback because your experience and the quality and safety of the care we deliver to you is our number one concern.

More Information on our website

Our website www.nesurgery.com will provide many details regarding our physicians and our practice.

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How did you Hear about our Practice

Patient Name: ______________________________ **Today's Date** ___________

City/Town you live in____

Office you are visiting today ____

Reason for your visit today?

	Dermatologic Surgeon	Plastic Surgeon	Oculoplastic Surgeon (Eye)
New Visit (problem)	☐	☐	☐
Cosmetic Visit		☐	☐

How did you hear about our practice? (check as many that apply)

1	Referred by a physician	______	Name of Physician _______________
2	Referred by a friend	______	Name of Friend _______________
3	Referred by a family member	______	Name of Family Member_______________
4	Emergency Room	______	
5	An Employee	______	Name of Employee _______________
6	Yellow Pages	______	
7	Yellow Pages on Internet	______	
8	Insurance Company	______	Name of Company _______________
9	Internet Web Browsing	______	Name of Search Engine _______________
10	Other advertising	______	Which one? _______________
11	Other not listed	______	Explain _______________

Thank you for taking the time to complete this questionnaire

Jan 2010

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Surgery Consultation Form

Name: ______________________________ Date: __________
First Middle Last

Date of Birth____/____/____ Age: __________ Referring Physician: ____________________

1. *Chief complaint*

What is the main reason for your visit? ______________________________

Have you had skin cancer in the past? ______________________________

2. *History of Present Illness* check all that apply

☐ My doctor referred me for a consultation

☐ I have a skin cancer which has been sampled (biopsied) by my doctor (fill in below)

	Biopsy result	Area on body	Biopsy date	Has the site been treated before?	How long has the growth been present?	In the past it has been....?
1	☐ Basal cell ☐ Squamous cell ☐other			☐Yes ☐No Type of treatment ☐excision ☐burned/scraped		bleeding ☐Yes ☐No painful ☐Yes ☐No increase in size ☐Yes ☐No unable to heal ☐Yes ☐No
2	☐Basal cell ☐Squamous cell ☐other			☐Yes ☐No Type of treatment ☐excision ☐burned/scraped		bleeding ☐Yes ☐No painful ☐Yes ☐No increase in size ☐Yes ☐No unable to heal ☐Yes ☐No
3	☐Basal cell ☐Squamous cell ☐other			☐Yes ☐No Type of treatment ☐excision ☐burned/scraped		bleeding ☐Yes ☐No painful ☐Yes ☐No increase in size ☐Yes ☐No unable to heal ☐Yes ☐No

3. *List All Medications* (also list over the counter medications and supplements- Please list dosages of these)

1. Aspirin ☐yes ☐ no	2. Plavix ☐yes ☐ no	3. Coumadin ☐yes ☐ no	4
5	6	7	8
9	10	11	12
13	14	15	16

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Surgical Form
Page Two
(Revised 08/17/10)

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Patient Name: ____________
DOB: ____________
Today's Date: ____________

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4. Allergies to medications

Medication	Reaction	Medication	Reaction

5. Medical History (previous and current health conditions)

Have you ever had any of the following?

	Yes	No		Yes	No
Pacemaker			Leukemia		
Need antibiotics before dental work			High blood pressure		
Artificial heart valve			Atrial fibrillation		
Heart murmur			Abnormal heart rhythm		
Artificial joint - if yes – when was surgery performed? Date:			Heart attack (myocardial infarction)		
Organ transplant			Stroke		
Bleeding problems			Temporary visual loss		
Difficulty healing			Liver disease		
Infections after surgery			Kidney disease		
Sores inside nose			Glaucoma		
Previous exposure to HIV virus			Previous exposure to hepatitis virus		
Other cancers:			Type cancer:		

Any other medical conditions ____________

6. Social History

Occupation____________ Employer____________

Smoker Yes ☐ No ☐

7. Family History

	Self	Family Member
Skin cancer (Basal Cell/squamous cell)	Yes ☐ No ☐	Yes ☐ No ☐
Melanoma	Yes ☐ No ☐	Yes ☐ No ☐

8. Review of Systems

Have you experienced any of the following within the last 30 days?

Symptom	Yes	No	Symptom	Yes	No
Fever			Hearing changes		
Loss of weight			Numbness of skin		
Changing skin lesion			Excessive tearing		
Enlarged glands			Sensitivity to bright light		
Headaches			New Cough		
Visual changes					

All information from this form is entered into your electronic medical record

I have reviewed all information on this form.
Patient Signature: ____________ Date: ____________