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.

<u>The packet includes</u>:
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 Wellesley Office:
49 Walnut Park, Building 4
Wellesley Hills, MA 02481
Phone: (781) 431-0060
Fax: (781) 431-0062
www.nesurgery.com

If you are using a GPS System, please use
49 Walnut Street, NOT Walnut Park

If you are coming from the NORTH:

1. Proceed along Route 95/128 South
2. Take exit 21B (Grove Street/Wellesley)
3. Go towards Route 16 Wellesley
4. At the traffic light intersection with Route 16, stay in the middle lane and proceed straight through the intersection onto Walnut Street (do not go back onto the ramp to the highway)
5. Once on Walnut Street, turn right at the 49 Walnut Park Sign and bear left with the road
6. Follow the road all the way to the back (see map on reverse side of this sheet)
7. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

If you are coming from the SOUTH:

1. Proceed along Route 95/128 North
2. Take exit 21
3. Turn left on Washington Street (Route 16)
4. Get in the left lane
5. At the traffic light, bear to the left. This will take you onto Walnut Street
6. Turn right at the 49 Walnut Park sign and bear left with the road.
7. Follow the road all the way to the back (see map on reverse side of this sheet)
8. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

If you are coming from the WEST on Route 9:

1. Take Route 9 East
2. Exit at Cedar Street. Turn left at Cedar Street, crossing over Route 9
3. Follow until you come to traffic light where you will bear right onto Walnut Street
4. Look for the sign that says 49 Walnut Park and turn left into park and bear left with the road
5. Follow the road all the way to the back (see map on reverse side of this sheet)
6. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

If you are coming from the EAST on Route 9:

1. Take Route 9 West and go under Route 95
2. Exit at Cedar Street and continue right onto Cedar Street heading toward Newton Lower Falls.
3. Follow until you come to traffic light, bear right onto Walnut Street
4. Look for the sign that says 49 Walnut Park and turn left into park and bear left with the road
5. Follow the road all the way to the back (see map on reverse side of this sheet)
6. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

If you are coming from Wellesley Center on Route 16:

1. Follow Route 16 East, Turn right onto Walnut Street
2. Continue straight through the light at Cedar Street
3. Look for the sign that says 49 Walnut Park and turn left into park and bear left with the road
4. Follow the road all the way to the back (see map on reverse side of this sheet)
5. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

If you are coming from Newton or the Newton-Wellesley Hospital Area on Route 16:

1. Take Route 16 West, continue to follow and cross over Route 128
2. Continue west and take a left onto Walnut Street
3. Look for the sign that says 49 Walnut Park and turn right into park and bear left with the road
4. Follow the road all the way to the back (see map on reverse side of this sheet)
5. Northeast Surgery Center is the last building on the left. Our office is in the same building as EPill. We have white pillars at the front entrance

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Map showing location of the Wellesley Hills Office of Northeast Surgery Center. Note that the mailing address is 49 Walnut Park, but the office is located in Building 4 at the back of the office complex at 49 Walnut Street.

WE ARE LOCATED IN BUILDING 4

NORTHEAST SURGERY CENTER

ePill

ASA

49

65 Walnut Street

15-35 Walnut Street

WALNUT STREET

Enter the office complex at 49 Walnut Street

90
95
16
Beacon Street
Exit 21/21a
49
16
Walnut Street
95
9

Inset shows the Wellesley Hills Office convenient location to the Mass Pike, Route 128 (95), and Route 9.

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

54 Baker Ave. Ext., Suite 201
Concord, MA 01742
978.287.8520 Fx 978.287.8519

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

NORTHEAST
SURGERY CENTER LLC
State-of-the-Art Care

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 Participating Insurances and Self Pay

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

For All Insurances

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

Medical Record Copy Fee

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

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.

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.

Returned Checks

There is a $25.00 fee on all returned checks.

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.

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

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)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW NORTHEAST SURGERY CENTER, LLC. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Northeast Surgery Center, LLC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Northeast Surgery Center, LLC or received by Northeast Skin Surgery Center, LLC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Northeast Surgery Center, LLC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Northeast Surgery Center, LLC reserves the right to change the terms of this Notice and to make any provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

Northeast Surgery Center, LLC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
Consultations between healthcare providers concerning a patient;
Referrals to other providers for treatment;
Referrals to nursing homes, foster care homes, or home health agencies.

For example, Northeast Surgery Center, LLC may determine that you require the services of a specialist. In referring you to another doctor, Northeast Surgery Center, LLS may share or transfer your healthcare information to that doctor.

Healthcare operations may include:

Contacting healthcare providers and patients with information about treatment alternatives;
Conducting quality assessment and improvement activities;
Conducting outcomes evaluation and development of clinical guidelines;
Protocol development, case management, or care coordination;
Conducting or arranging for medical review, legal services, and auditing functions.

For example Northeast Surgery Center, LLC may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Northeast Surgery Center, LLC may contact you by phone, or mail to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders and a form will be given to you at registration that you will complete with these instructions.

We may not disclose your protected health information to family members or friend who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Northeast Surgery Center, LLC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following;

As permitted or required by law.

In certain circumstances we may be required to report individual health information to legal authorities, such as Law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, Neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any wound To law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities.

We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities.

We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform any legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable disease.

Judicial and Administrative Proceedings.

Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order.
A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

For activities related to death.

We may disclose patient healthcare records to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death.

For research.

Under certain circumstances, and only after a special approval process, we may use and disclose your healthcare information to help conduct research.

To avoid a serious threat to health or safety.

We may report a patients name and other relevant data to the Department of Transportation if it is believed the patient's vision, physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For workers' compensation.

We may disclose your healthcare information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Northeast Surgery Center, LLC will not make any other use or disclosures of your health information without your written authorization. You may revoke such authorization at any time, except to the extent that Northeast Surgery Center, LLC has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your health information by Northeast Surgery Center, LLC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Northeast Surgery Center, LLC may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Northeast Surgery Center, LLC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Northeast Surgery Center, LLC not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing on the form provided at registration. We will accommodate reasonable request by you. You have the right to request that Northeast Surgery Center, LLC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosure of your health information made by Northeast Surgery Center, LLC for the six years prior to the date of the request, beginning with the disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Northeast Surgery Center, LLC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Northeast Surgery Center, LLC please contact the Privacy Officer at the following:

Privacy Officer
Northeast Surgery Center, LLC
33 Village Square
Chelmsford, MA 01824

It is the policy of Northeast Surgery Center, LLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003
This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

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.

NORTHEAST
SURGERY CENTER LLC
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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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Medical History Form

Name:____ Date: ______________
First Middle Last

Date of Birth: _____/_____/_____ Age: _______ Referring Physician: __________________

Chief Complaint:

What is the main reason for your visit? ___________________________________

Medical History:

Height: ______ft. ______in. Weight:______

	List Major Illnesses and Dates		
1		4	
2		5	
3		6	

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease			Diabetes			Asthma		
Stroke			Cancer			Kidney Disease		
High Blood Pressure			Skin Cancer including Melanoma			Thyroid Disease		
Rheumatic Fever			Blood Clots/Embolism			AIDS/HIV		
Anemia			Poor healing			Hepatitis		
Glaucoma			Bleeding problems			Atrial fibrillation		
Arthritis			Stomach ulcers			Heart murmur		
Depression			Anxiety					

Surgical History:

	Please List Surgeries and Dates		
1		3	
2		4	

Medications:

Aspirin: □ Yes □ No Plavix: □ Yes □ No Coumadin: □ Yes □ No

	List all prescriptions and over the counter medications with doses		
1		4	
2		5	
3		6	

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Medical Form
Page Two

NORTHEAST
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Patient Name: ______________
DOB: ______________
Today's Date______________

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Allergies to Medications:

Medication	Reaction	Medication	Reaction

Family History: (Please note if this relates to you or a family member)

	Yes	No		Yes	No		Yes	No
Breast Cancer			Skin Cancer			Diabetes		
Heart Disease			Melanoma			Kidney Disease		

Review of Systems: (*Have you experienced these symptoms within the 30 days?)*

	Yes	No		Yes	No		Yes	No
Cough			Fever			Swollen feet/ankles		
Diarrhea			Skin rash			Shortness of breath		
Depression			Swollen glands			Headaches		
Chest pain			Joint/muscle pain			Dry eyes		
Weight change			Changing mole			Mood swings		

Social History:
Occupation: ______________ Employer: ______________
Smoking History: (Y/N) ______ #packs ______ #years ______________Date Quit Smoking
Alcohol Use (type and amount): ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow / Widower

Children: ______________

I verify that the above information is true and accurate to the best of my knowledge. I consent to the use of my records and photographs for educational, credentialing and testing purposes.

______________ ______________
Signature of Patient/Parent if minor Date

I HAVE REVIEWED ALL INFORMATION ON THIS FORM.

______________ ______________
Doctor Signature Date (revised 11/11/11)

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