



**NORTHEAST  
SURGERY CENTER**

*State-of-the-Art Care*

[www.nesurgery.com](http://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](http://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](http://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](http://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)
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**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)
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**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)
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**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
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Concord, MA 01742  
978.287.8520 Fx 978.287.8519

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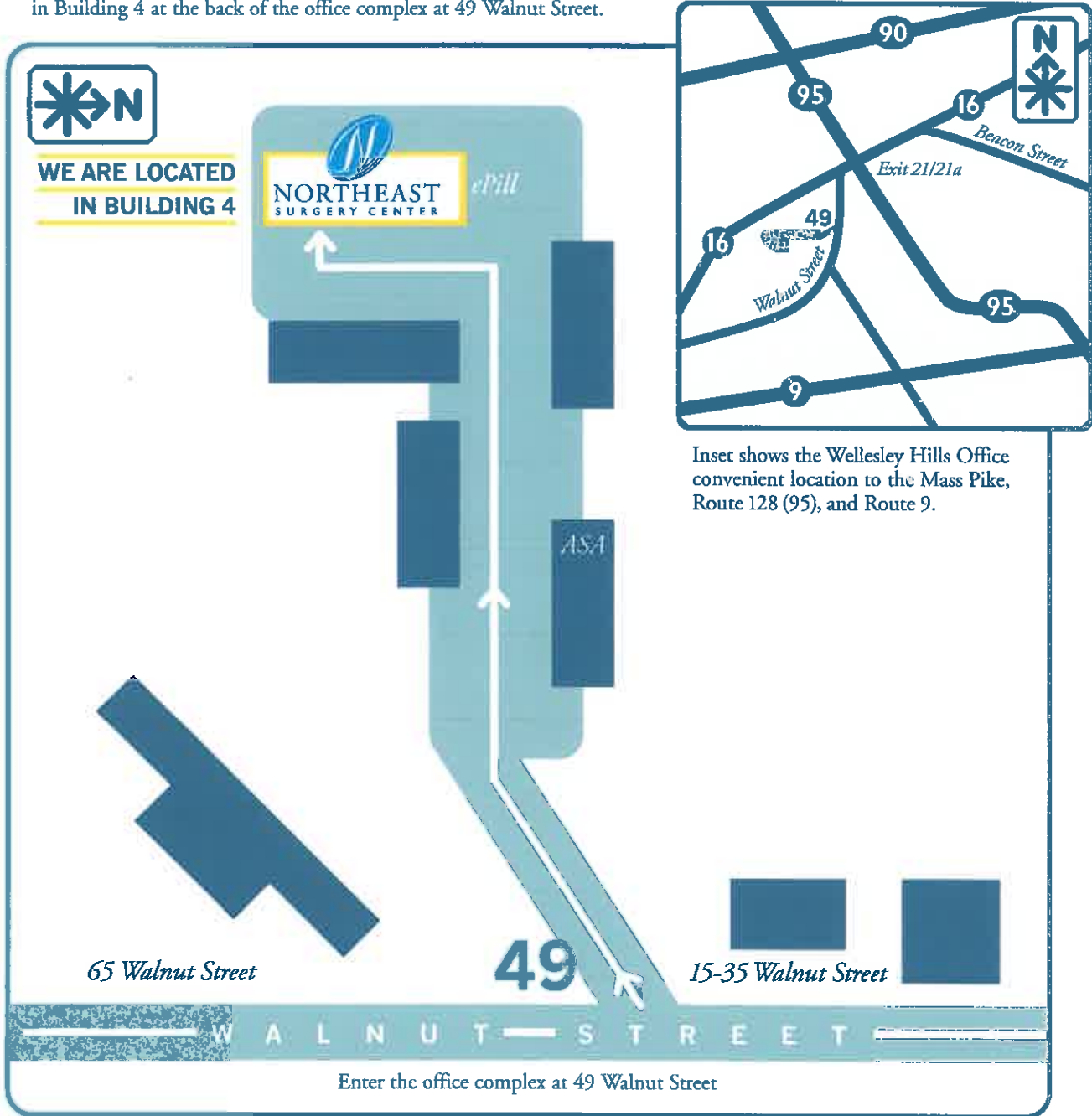
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Map showing location of the Wellesley Hills Office of Northeast Surgery Center. Note that the mailing address is 49 Walnut Park, but the office is located in Building 4 at the back of the office complex at 49 Walnut Street.



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**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](http://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 All insurance cards and ask that you present them at Each 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.

**Payment Methods** - 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)

### 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



## **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](http://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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Visit		<input type="checkbox"/>	<input type="checkbox"/>

**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**



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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	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> other			<input type="checkbox"/> Yes <input type="checkbox"/> No Type of treatment <input type="checkbox"/> excision <input type="checkbox"/> burned/scraped		bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No painful <input type="checkbox"/> Yes <input type="checkbox"/> No increase in size <input type="checkbox"/> Yes <input type="checkbox"/> No unable to heal <input type="checkbox"/> Yes <input type="checkbox"/> No
2	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> other			<input type="checkbox"/> Yes <input type="checkbox"/> No Type of treatment <input type="checkbox"/> excision <input type="checkbox"/> burned/scraped		bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No painful <input type="checkbox"/> Yes <input type="checkbox"/> No increase in size <input type="checkbox"/> Yes <input type="checkbox"/> No unable to heal <input type="checkbox"/> Yes <input type="checkbox"/> No
3	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> other			<input type="checkbox"/> Yes <input type="checkbox"/> No Type of treatment <input type="checkbox"/> excision <input type="checkbox"/> burned/scraped		bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No painful <input type="checkbox"/> Yes <input type="checkbox"/> No increase in size <input type="checkbox"/> Yes <input type="checkbox"/> No unable to heal <input type="checkbox"/> Yes <input type="checkbox"/> No

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

1. Aspirin <input type="checkbox"/> yes <input type="checkbox"/> no	2. Plavix <input type="checkbox"/> yes <input type="checkbox"/> no	3. Coumadin <input type="checkbox"/> yes <input type="checkbox"/> no	4
5	6	7	8
9	10	11	12
13	14	15	16



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Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Today's Date: \_\_\_\_\_

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Suzanne K. Freitag, M.D.  
OCULOPLASTIC SURGERY

**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**

	<u>Self</u>	<u>Family Member</u>
Skin cancer (Basal Cell/squamous cell)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Melanoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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: \_\_\_\_\_