

Medical Associates of Greater Boston

307 West Central Street
Natick, MA 01760
Telephone: 508-820-8383
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Wendy J. Parker, M.D.
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Natalia Sedo, N.P.
Christine Chang, M.D.

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioner, medical assistants, and office staff work closely in a “team approach” to support your patient care.

Our office is open **Monday through Friday from 8:00am–5:00pm**. Evening appointments are available every **Tuesday until 7:00pm**. Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. After hours care will be provided by the on-call physician, who can be reached by calling our office directly.

As your primary care physician, we work collaboratively with Newton-Wellesley Hospital and a wide range of Newton-Wellesley Hospital physician specialists to coordinate all aspects of our patient care including inpatient hospitalization and specialty consultation care, as needed.

Before you visit, please notify your health insurance company of your new primary care provider if required. We also request that you contact your previous physician and specialists and request that a copy of your medical record be sent to us. If your former providers are affiliated with the Partners network this should not be necessary.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. **Please bring your health insurance identification card as well as a photo I.D.** Please bring a **complete list of all of your medications**, as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Providers and Staff of Medical Associates of Greater Boston

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Welcome to Your Patient-Centered Medical Home

Thank you for choosing us to be part of your health care team. We are committed to providing you the best health care possible by becoming a patient-centered medical home.

What is a patient-centered medical home?

A patient-centered medical home is a system of care in which a team of health professional's work together to provide all of your health care needs. Our goal is to provide care that is personalized for you.

Who is part of my medical home team?

Your primary care provider leads your care team. Other members include:

- Nurse practitioners
- Nurses
- Medical assistants
- Care managers
- Practice support staff

The members of our team act as “coaches” who help you get healthy and stay healthy and provide the services that are right for you.

What Can You Expect?

In a patient-centered medical home, we:

- **Help you understand your condition(s)** and how to take care of yourself. We explain your options and help you make decisions about your care. We provide you with educational materials specific to your health.
- **Know you and your health history.** We know about your personal or family situation and can suggest treatment options that make sense for you.
- **Provide appointments at times that are convenient for you.**

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- **Address behavioral health issues.** Our practice can screen and treat you for behavioral health issues (such as depression) and connect you with other providers.
- **Coordinate care to a trusted specialist, when needed,** within Newton-Wellesley Hospital and the Partners Network. Your medical team and specialists work together and share the same electronic medical record system. This allows coordination of care so you can get better faster.
- **Help transfer records from last provider.** We can make your transition seamless. Contact us to get started.

Patient Portal (for non-urgent communication):

<http://www.patientgateway.com>

- Our secure portal allows patients and care teams to interact, before, during and after office hours.
- Patients can schedule their own non-urgent appointments, medication refills and referrals.
- The portal allows patients to check lab and test results.

After Hours/Urgent Care:

A physician is available 24/7 for telephone consultation. Call our office and a physician will be paged for you.

Newton-Wellesley Hospital offers Urgent Care in Waltham. The Urgent Care Center is on our electronic medical record system so providers will have access to your medical history and needs.

Newton-Wellesley Urgent Care Center - Waltham
9 Hope Avenue (Located in the Children's Hospital Building)
Waltham, MA 02453 617-243-5590

We want you to be involved in your health care decisions. How can you help?

Be an active team player:

- Ask health questions so you understand your diagnosis and needs.
- Communicate with your medical home team.
- Tell us about your other health care providers, including visits to the emergency department or urgent care.

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Take care of your health:

- Collaborate with the team to develop your health care plan.
- Set reachable goals.
- Make sure you understand how to follow the plan.
- Tell your team if you have trouble following the plan or taking your medications.
- Review the plan and change the goals as needed.

Have a checklist for your appointment.

- Bring a list of your questions with you.
- Ask the most important ones first.
- Write down the answers.
- Before you leave the office, be sure you know what you need to do until your next visit.

Office Hours (will get once we know the set up)

For appointments, cancellations and prescription refills, please call our office during regular office hours. Patients can also use the Patient Portal to schedule non-urgent appointments at <http://www.patientgateway.com>.

Translation Services

If you require a translator, please let us know in advance of your appointment and we will arrange for an interpreter.

Need Health Insurance?

Apply for health and dental insurance through the Massachusetts Health Connector at www.mahealthconnector.org.

We offer equal access to our services regardless of your insurance status.

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MAOGB MEDICAL HISTORY FORM

PATIENT NAME _____

DOB: _____

Do you have any of the following problems?

- Acid reflux
- Alcoholism/other addiction(s)
- Allergies (environmental)
- Anxiety
- Asthma
- Atrial fibrillation
- Cancer (specify type: _____)
- Coagulation (bleeding or clotting) problem
- High cholesterol

- Diabetes mellitus
- Erectile dysfunction
- Heart disease (specify type: _____)
- Hypertension (high blood pressure)
- Irritable bowel syndrome)
- Migraines
- Osteopenia/osteoporosis
- Prostate problem
- Thyroid problem
- Chronic low back pain
- Depression
- Other problems (list below): _____

<u>Operation</u>	<u>Date</u>

SURGICAL HISTORY: (Please list all prior operations and dates):

I have had no prior surgery.

<u>Operation</u>	<u>Date</u>

<u>Medical Condition</u>	<u>Relation</u> (mother, father, sister)
Alcoholism	
Anemia	
Anesthesia problem	
Arthritis	
Asthma	
Birth defects	
Bleeding problem	
Cancer (breast)	
Cancer (colon)	
Cancer (skin)	
Cancer (ovarian)	
Cancer (prostate)	
Cancer (other)	
Colon polyps	
Depression	
Diabetes, Type 1 (child)	
Diabetes, Type 2 (adult)	
Eczema	
Epilepsy (seizures)	

FAMILY HISTORY: Please indicate with a check (✓) family members who have had any of the following conditions:

I do not know my family history.

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MAOGB MEDICAL HISTORY FORM

<u>Medical Condition</u>	<u>Relation</u> (mother, father, sister)
Genetic diseases	
Glaucoma	
Hay fever (allergies)	
Hearing problems	
Heart attack (CAD)	
High blood pressure	
High cholesterol	
Kidney diseases	
Lupus (SLE)	
Mental retardation	
Migraine headaches	
Mitral valve prolapse	
Osteoarthritis	
Osteoporosis	
Rheumatoid Arthritis	
Stroke (CVA)	
Thyroid disorders	
Tuberculosis	
Other:	

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AUTHORIZATION TO RELEASE INFORMATION

(Please allow 3-4 weeks for processing)

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

Name of Provider/Clinic/Organization

Name of Provider/Clinic/Organization

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Phone: _____ Fax: _____

Phone: _____ Fax: _____

I authorize the following information to be disclosed: (Please initial)

_____ Entire Record

_____ Specific Information

REASON for disclosure of this authorization: (Please initial)

_____ Continuing Care

_____ I will no longer be a patient of Medical Associates

_____ Legal

_____ Job

_____ Other: _____

ADDITIONAL PATIENT INFORMATION:

*I understand that I have the right to withdraw this authorization.

*I understand that I do not have to sign this authorization to receive treatment.

*This request shall remain in effect for 90 days unless specifically revoked in writing; however, such revocation does not affect any actions taken by MAOGB before receipt of the revocation.

*Failure to fill this authorization out in its entirety and sign will result in a delay and MUST be read completely.

*I understand that signing this authorization does not cancel any rights I have under the state/federal laws.

*There may be a processing fee with a maximum fee of \$50.00 (Under the privacy rule, medical practices may charge patients a reasonable and cost based charge for copying records.)

X _____ Date: _____

Client Signature (Legal Representative, if applicable)

Relationship

**HIV and AIDS information authorization: Specific authorization is required for any HIV-related information.

X _____ Date: _____

Client Signature (Legal Representative, if applicable)

Relationship

**Sensitive Information Authorization: Separate authorization is required to release sensitive information, such as: abortion, substance abuse, genetic information, mental health notes, STD's, rape and abuse.

X _____ Date: _____

Client Signature (Legal Representative, if applicable)

Relationship

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Patient Registration Form

Patient Information

Name: _____ DOB: _____
First Name Last Name

() Female () Male Marital Status: _____ SS#: _____

Home Address: _____
Street City/Town Zip Code

Home #: _____ Cell#: _____ Work # _____

Preferred # () Home () Cell () Work

Emergency Contact Person _____
Name Phone #'s

Relationship to patient _____

Your Occupation: _____ Preferred Language: _____

Ethnicity: () Hispanic or Latino () Not Hispanic or Latino () Decline

Race: () Native American Indian () Asian () Black or African American

() White Other _____ () Decline

For Gateway Patient Portal Use (Online access to request appointments, refills, receive lab results, etc. For information how to sign-up, please inquire with our staff.)

E-Mail Address: _____

Primary Insurance Carrier

Additional Insurance Carrier

Name of Insurance Co _____ Name of Insurance Co _____

Name of Subscriber _____ Name of Subscriber _____

Subscriber's SS# _____ Subscriber's SS# _____

Policy # _____ Group# _____ Policy # _____ Group# _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Relationship to Patient _____ Relationship to Patient _____

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Referral/PCP: If your insurance company requires you to choose a primary care physician (PCP) it is your responsibility to notify the insurance company that you have chosen your new physician. If you need an insurance referral to see a specialist, you must notify our office before the specialist's visit. If you have an outside PCP, you must obtain a referral for today's visit.

Please sign acknowledging your understanding of the above statement and the above information that you have provided is true to the best of your knowledge.

Patient/Guardian

Date

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NOTICE OF PRIVACY PRACTICES

This notice describes the privacy policies of our practice.

Our Obligations: Our office considers your privacy a priority. We follow strict federal and state guidelines to maintain the confidentiality of your protected health information. (PHI).

Protected Health Information: Protected Health Information (PHI) is any information about your past, present or future healthcare or payment for that care that could be used to identify you. Members of our workforce and our business associates may only access the minimum amount of protected health information they need to complete their assigned tasks.

We may use your PHI in order to treat you, obtain payment for services provided to you and conduct our normal business known as Health Care Operations. Examples of how we use and disclose information include:

Treatment – We document each visit. This includes test results, diagnosis, medications, and therapies. This allows our staff to provide the best care to meet your needs.

Payment – We use PHI to obtain payment for services we provide for you. We may tell your health plan about upcoming treatment or services that require prior approval.

Health Care Operations – We may use PHI in our internal operations in order to improve the quality of care and customer service we deliver to you.

Disclosure to Family, Friends and Caregivers – We may disclose PHI to a person identified by you, with your verbal or written consent. If you are incapacitated or in an emergency situation, we may exercise our professional judgment to determine whether disclosure is in your best interest.

Public Health Activities – We may disclose PHI for the following reasons: for public health such as disease tracking; to report abuse or neglect; for coroners or medical examiners; for workmen's compensation; for correctional institutions; for national security; for organ donation; to avoid serious public health or safety threat.

Highly Confidential Information – the law requires special protections for the following information: HIV/AIDS status; genetic testing; psychiatric information; substance abuse/controlled substance use; venereal disease; abortion; A separate, specific authorization is required to release this information.

You may revoke your authorization at any time.

Our Responsibilities -We are required by law to maintain the privacy of your medical information, provide this notice of our duties and privacy practices and abide by the terms of the notice currently in effect. We reserve the right to change privacy practices and to make new practices effective for all information we maintain. New policies will be posted in our office and available from our staff.

Your Rights- You have the right to request a restriction on the use of your PHI, however we are not required to abide by the request. You may request that we communicate with you at a specific phone number or address. You may inspect or copy your information, however, this request must be made in writing and a reasonable fee may be charged for copying; you may request that your record be amended, however you must have a reason for the amendment; you have a right to an accounting of the disclosures. This does not apply to disclosures prior to November 30, 2004; you have the right to a paper copy of this notice.

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If you have any questions about this notice, please contact our privacy officer who is the office manager.

If you would like to exercise your rights or feel your rights have been violated, contact the privacy officer.

All complaints will be investigated and you will not suffer retaliation for filing a complaint. You may also file a complaint with the department of Health and Human Services in Washington, D.C.

Our Office Manager can be reached at

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