

Westford Internal Medicine 133 Littleton Road Suite 202 Westford, MA 01886
Phone: 978-577-1946 Fax: 978-692-4716 Referral: 978-577-1929 Prescription refills: 978-577-1945

WELCOME TO WESTFORD INTERNAL MEDICINE

We would like to bring the following policies and procedures of the office to your attention:

Appointments:

Visits are made by appointment only

Cancellations:

We require having a 24 hour notice for any cancellation or rescheduling of your appointments. This allows us to contact other patients who may be waiting for appointments. There is a \$50 fee for any annual OMT or physical appointment that is cancelled with less than 24 hour notice or not attended as scheduled and a \$25 fee for all other appointments.

Late to appointment:

We ask that you please arrive to your appointment on time, as told at the time of scheduling. If you are 10 minutes late or more, you will be likely asked to reschedule unless the physician/nurse practitioner's schedule can accommodate your appointment.

Telephone calls:

If you are having a medical emergency, please call 911. We are available for telephone calls during normal business hours, Monday through Thursday 8:30 am to 5:00 pm, Friday 8:30 am to 4:30 pm, and Saturday 8:30 am to 12:30 pm. If you are calling after normal business hours, you will be connected to our answering service. If urgent, the answering service will relay your message to the physician or nurse practitioner on call. Otherwise, the answering service will forward your message to the office and your call will be returned during normal business hours.

Medication Refills:

If you need a medication refill, we ask that you contact the prescription refill line at 978-577-1945. You can access this line 24 hours a day. We ask that you allow 72 hours to refill your medications. If you have an urgent request for a medication, please call the main phone number and speak to a receptionist.

Diagnostic Testing/Laboratory Results:

All diagnostic testing and laboratory results will be communicated to you within a two week time-frame, by phone, letter, or email. If you do not receive your results within this two week time-frame, please contact the office.

Referrals:

It is the patient's responsibility to obtain a referral for all specialty visits. Patients with managed care or HMO/POS plans, referrals will be made within the Emerson Hospital network. All out of network referrals are approved on a case by case basis. If you are being seen in the office and your provider refers you to a specialist, please stop at our referral desk prior to leaving the office to request your referral. If you are calling for a referral, please call the referral line at 978-577-1929 and leave the following information: The patient's name, date of birth, your phone number in case we need to reach you with questions, the physician's name you are seeing, the date of your visit, the reason you are seeing the physician, and if available, the NPI number for the physician you are seeing.

We thank you for the opportunity to care for you.

WESTFORD INTERNAL MEDICINE

Name: _____ Date of Birth: _____

Any other names used: _____

Sex: Male female Marital status: S M W D Language: _____

Ethnicity: Caucasian Black Hispanic/Latino Asian Other _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Contact: Home phone Cell phone Work phone

May we contact you and/or leave detailed messages with medical information? Home Y N Cell Y N Work Y N

Would you like access to our patient portal? Y N Email address: _____

Pharmacy name and location: _____

Mail order pharmacy name and location: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Subscriber's name (other than patient): _____ Subscribers date of birth: _____

Relationship to patient: _____ Subscribers Social Security #: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Subscriber's name (other than patient): _____ Subscribers date of birth: _____

Relationship to patient: _____ Subscribers Social Security #: _____

Emergency contact: _____ Relationship to patient: _____

Phone number: _____

May we discuss your emergent condition with any member of your family? Y N If yes, whom? Name: _____

Relationship to patient: _____ Others: _____

This information is given for the purpose of establishing an account and medical file with Westford Internal Medicine. It is understood that I shall be responsible for all charges incurred by me (or my dependent as noted above). I authorize the release of payment for any insurance claims being made directly to Westford Internal Medicine as well as the release of medical information for processing insurance payments.

Patient signature: _____ Date: _____

Patient representative if unable to sign): _____ Relationship: _____

Office Use Only:

Patient signature: _____ Date: _____

Patient representative if unable to sign): _____ Relationship: _____

WESTFORD INTERNAL MEDICINE HEALTH HISTORY FORM

Name: _____

Date of Birth: _____

Medical history: Please check the appropriate column if you have ever been diagnosed with the following illnesses.

High blood pressure	YES/NO	Diabetes	YES/NO	High Cholesterol	YES/NO
Cancer	YES/NO	Thyroid Problems	YES/NO	Heart Problems	YES/NO
Asthma/lung problems	YES/NO	Liver Problems	YES/NO	Anemia	YES/NO
Stroke	YES/NO	Headaches	YES/NO	Kidney Stones	YES/NO
Arthritis	YES/NO	Prostate problems	YES/NO	Anxiety or Depression	YES/NO
Gout	YES/NO	Stomach Problems (heartburn, ulcers) YES/NO			

Intestinal problems (colitis, Irritable bowels, chronic diarrhea, constipation, or black/tarry stools) YES/NO

Any other problems: _____

Have you had any previous surgery? YES/NO Type of surgery and when _____

Immunizations: Have you had the following immunizations and when?

Flu Vaccine: _____ TDAP: _____ Tetanus: _____ MMR (Measles/umps/Rubella): _____

Pneumonia vaccine: _____ Hepatitis A: _____ Meningococcal: _____ Hepatitis B _____

Medications: Please list ALL medications you are currently taking. Include vitamins, herbs, calcium supplements, and medications that you take on an as needed basis (ex: Tylenol, allergy pills, etc.): _____

Do you have any allergies to medications? YES/NO If yes, please list medication and reaction.

Do you have environmental allergies such as pollen, grasses, dog/cats, bee stings? YES/NO If yes, please list:

WESTFORD INTERNAL MEDICINE HEALTH HISTORY FORM PAGE 2

Name: _____

Date of Birth: _____

Family Medical History: Please list the medical history for all your immediate blood relatives. (Specifically any heart disease, cancer, or diabetes).

	Present age	Medical problems	Age at Death/reason
Father			
Mother			
Brothers			
Sisters			
Children			

Do you smoke? YES/NO If yes, how many cigarettes do you smoke each day? _____ how old were you when you started smoking? _____

Do you drink alcohol? YES/NO If yes, how much do you drink each week? _____

Are you feeling threatened by anyone that you know? YES/NO if yes, would you like to discuss this? YES/NO

Are you at risk for HIV? YES/NO

Does your house have smoke detectors? YES/NO

Do you exercise? YES/NO if yes, what type of exercise and how often? _____

Do you wear your seatbelt? YES/NO

Please circle your physician or nurse practitioner: Cohen Taylor McCarthy Huynh Jacobellis Azam Tsyrukunova Kremnick Hall Hoang Rushton

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

WESTFORD INTERNAL MEDICINE ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive or review a copy of Westford Internal Medicine’s Notice of Privacy Practices. By signing below, I am acknowledging that I have received or have had the opportunity to receive or review the Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____

Date of Birth: _____

Date: _____

If you would like to share your information with any member(s) of your family, friends, or caretakers, please list their names and relationships below. By listing names below, you authorize Westford Internal Medicine to discuss/release my protected health information to the individual identified.

<u>NAME</u>	<u>DATE OF BIRTH</u>	<u>RELATIONSHIP</u>
• _____		
• _____		
• _____		
• _____		
• _____		

I authorize Westford Internal Medicine to discuss my medical care with the individual(s) identified above. I understand there is no expiration date, and I may add or delete individuals at any time. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been provided in response to this release.

****WOULD YOU LIKE THE NAMED ABOVE TO PICK UP PRESCRIPTIONS FOR YOU? YES NO ****

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Signature: _____ Date: _____

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information will be released by signing:

Signature: _____ Date: _____

In addition to the above signatures, I would like information relating to HIV/AIDS testing/treatment released to the above party(s).

Signature: _____ Date: _____

WESTFORD INTERNAL MEDICINE ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

HIPAA Omnibus Notice of Privacy Practices effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental condition and related health care services.

Your Rights- When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost based fee.

Ask us to correct your medical record- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications- You can ask us to contact you in a specific way, for example home or office, or send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take action.

File a complaint if you feel your rights are violated- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Complaints- You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. Our HIPAA Compliance Officer is Wendy Rott. She can be reached at 978-577-1920, or email at wrott@PCPO.partners.org.

Your Choices- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases you have both the right and choice to tell us to Share information with your family, close friends, or others involved in your care, Share information in a disaster relief situation or include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, and most sharing of psychotherapy notes.

Our Uses and Disclosures- How do we typically use or share your health information? We can use your health information and share it with other professionals who are treating you. Example: a doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your service.

How else can we use or share your health information? We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues- We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Do Research-We can use or share your information for health research.

Comply with the law- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

We can share health information about you with organ procurement organizations. We can work with a medical examiner or funeral director, coroner when an individual dies. We can share information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order or in response to a subpoena.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. We are required by law to maintain the privacy of, and

provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number, 978-577-1946.

PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between healthcare providers that is intended to improve the quality and safety of patient care. I have received and had the opportunity to review the "Mass HIway: Fact Sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (Westford Internal Medicine). I hereby give the Practice permission to use Mass HIway to:

- Send to the Mass HIway my name, date of birth, gender, email, home address, phone number, and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.
- Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault, substance abuse records, reproductive health concerns, and genetic testing results.
- I understand that I may withdraw my permission for the Practice to share information)" (Opt-out) at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

Print Patient Name: _____

Patient Date of Birth: _____

Signature of Patient or Patients Legal Representative: (If applicable) _____

Print Name of Patient Representative: _____

Relationship to patient: _____

Date: _____

THE MA HIWAY FACT SHEET

The Mass HIway is a secure statewide computer network that allows your healthcare providers to safely and quickly send your health information to where it is most needed. A doctor or nurse can care for you better when he or she has important information about your health history. The Mass HIway is designed to make this safer and faster. The goal is better care coordination and quality for you and your family.

What is the Mass HIway?

Mass HIway is a secure statewide computer network that can help healthcare providers coordinate your care. It is a new tool that can be used to:

- Locate other members of your healthcare team.
- It securely requests, send, and receive your health information.
- It is voluntary.
- State Law requires all healthcare organizations get patient consent (by signing a consent form) before they may use the Mass HIway for that patient's care.

The Mass HIway is managed by the Commonwealth of Massachusetts' Executive Office of Health and Human Services (EOHHS).

How does the Mass HIway help me?

- If you are in an accident or have a sudden illness and go to the emergency room, the hospital might not know your medical history. The emergency room doctor can use the Mass HIway to find out if you are allergic to any medicines or if you have other health problems.
- If you were discharged from the hospital and are going for a follow-up appointment, the hospital can use Mass HIway to send your doctor a note about your hospital stay. Then, you and your doctor could spend time talking about your follow-up care instead of paperwork.
- If you get tests done, the doctor can use the mass HIway to send the results to other members of your healthcare team, like your specialists. This helps them coordinate your care. It can also save your time and money by reducing the need for repeat tests.
- If you have a chronic condition, your health insurer case manager can use the Mass HIway to communicate with your doctors to coordinate your care and help you stay healthy.
- If you see a new doctor, they can use the Mass HIway to locate other organizations where you have received care. Your new doctor can request your health information so they can treat you better.
- Remember, the Mass HIway is a new tool, so all of your providers may not be using it yet. There will be more benefits for you as more healthcare organizations use the Mass HIway.

Who can use the Mass HIway and why?

- Mass HIway may only be used by healthcare organizations (like doctors' offices, clinics, hospitals, public health agencies, and health insurers).

- Mass HIway may only be used for information sharing as allowed by law (to plan treatment, to get payment from insurance companies, and operations, like reporting care quality). Speak to your doctor or office staff about what information is sent and why.

Does the Mass HIway store my health information?

- No. The patient's medical record itself is **not** part of the Mass HIway system. The Mass HIway cannot see any health information sent over the network. The medical record is stored by the healthcare organization; the same way it is today.

What happens when I give my consent?

- With your consent, you allow the healthcare organization to send the following information about you to the Mass HIway to be stored in a secure database. This data is used to search for other healthcare organizations that have health information about you for request. **With your consent**, you allow your relationship to that organization to be listed in the Mass HIway network. A relationship means that you have received care at that organization and have given consent to that organization to use the Mass HIway. Your relationship can only be seen by other organizations where you have given consent.
- You allow healthcare providers or other health workers at that organization to use Mass HIway to request, send, and receive health information about you for your care. Examples of other health workers could be a lab technician or someone in the medical records office. Speak with your doctor or the office staff about who is using the Mass HIway at that organization.

What if I say "No" or don't sign the consent form? What if I change my mind?

- That's ok. But, if you do not consent for the Mass HIway, your providers will continue to send your health information using other ways, like fax or the mail. But that takes time and it's hard to control who reads a fax or opens a piece of mail, so your information may not always be protected. **The Mass HIway is designed to make this safer and faster.**
- Each healthcare organization will have its own process for you to change your choice, so speak with your doctor or the office staff to learn how.

How does the Mass HIway protect my information?

The Mass HIway has security measures in place to protect your information that aren't true of current methods, like fax, mail, or portable media like a CD or USB (Flash drive) such as:

- Using a special code so that only authorized providers can read the information sent over the Mass HIway (This is known as encrypting data).
- Encrypting the Mass HIway database of demographic information, and keeping it behind a firewall (this prevents access by the wrong people).
- Having a way to oversee who has access to the system and who has used it for a particular patient's healthcare. You can get a copy of this list by speaking with your provider or the office staff and asking for an "accounting of disclosures".
- A user must have valid usernames and strong passwords.

- All healthcare organizations using the Mass HIway have signed a contract to make sure they follow all state and federal laws to protect your information.
- You will still need to give special permission for providers to request and receive certain sensitive information. This includes HIV and genetic testing results and substance abuse.
- There is always a risk with technology, but the Mass HIway uses the highest security standards to protect your information. Most of the data breaches you hear about are from insecure laptops being lost, or information being sent without encryption (coding), like a CD or a USB (flash drive). The Mass HIway can help replace these methods.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Westford Internal Medicine 133 Littleton Road, Suite 202 Westford, MA 01886

Phone: 978-577-1946

Fax: 978-692-4716

Name: _____ Date of Birth: _____ Last 4 digits of SS#: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Release Information: I hereby authorize Westford Internal Medicine to:

Release my medical records to:

Obtain my medical records from:

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Purpose of request: Personal Continuing care (referral/2nd opinion) Legal other

Transfer of care (new primary care physician), if transferring, please explain: _____

Information to be released: (Please contact the office for information regarding fees for copying records)

Entire record Other _____

Abstract (Includes chart summary, immunization report, last 2 years of office visits & labs from last date seen and 5 years of diagnostic reports and consults from date on release form)

OR CD (You must sign all three signature spots for a CD it releases the entire record only)

This authorization is valid until _____ or if not specified for 180 days and maybe revoked at any time in writing prior to the expiration date. An additional authorization for re-disclosure beyond recipient is required.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(NOT VALID UNLESS WITNESSED)

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information will be released by signing:

Patient's Signature: _____ Date: _____

In addition to the above signatures I would like information relating to HIV/AIDS testing/treatment released to the above party.

Patient's Signature: _____ Date: _____

ALL AREAS OF FORM MUST BE COMPLETE FOR FORM TO BE VALID. INCOMPLETE FORMS WILL NOT BE PROCESSED.