



134 Rumford Avenue
Suite 208
Newton, MA 02466
Tel: (617) 431-4451
Fax: (617) 431-4456

Dear New Patient,

Thank you for choosing to make your first visit with us at Boston Osteopathic Health. We are looking forward to meeting you.

Enclosed find your new patient packet, which contains the most accurate directions to our office (back of this page), registration information, information disclosure consent, insurance information, and your initial office visit form. Please complete the relevant portions as accurately as possible and bring them along for your appointment. Also, fill out all high-lighted portions of the initial office visit form on page 1 and 2. **Lastly please plan to arrive 20 minutes early for your appointment time for registration process!**

Please feel free to contact our office with any questions or concerns about your upcoming visit. We are pleased to be a new part of your personal healthcare experience.

Best Regards,

The Staff at Boston Osteopathic Health

BOSTON OSTEOPATHIC HEALTH
134 RUMFORD AVE, SUITE#208
NEWTON, MA 02466

Please use these instead of internet directions. These are more accurate
HANDICAPPED PARKING AVAILABLE IN GARAGE UNDER BUILDING

Directions coming from the South:

Take Interstate 95N/MA-128North
Merge onto MA-30 (Commonwealth Ave) via exit 24
toward NEWTON/BOSTON 1.7 mi
Turn Left onto LEXINGTON STREET 0.8 mi
Turn Left onto RUMFORD AVE. 0.1 mi
***Turn Right into first drive (PACARD COVE OFFICE PARK).
134 Rumford Ave is the building set behind straight ahead across parking lot.
Our office is on the second floor, Suite #208***

Directions coming from the North:

Take interstate I-95S/MA-128 South toward LOWELL/WALTHAM
Merge onto MA-30(Commonwealth Ave) East via EXIT 24 toward NEWTON/BOSTON
1.1mi
Turn LEFT on LEXINGTON STREET 0.8mi
Turn Left onto RUMFORD AVE. 0.1mi
***Turn Right into first drive (PACARD COVE OFFICE PARK).
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Directions coming from the East/Boston:

Take I-90 West/MASS PIKE/MASSACHUSETTS
Take RT 16 East, EXIT 16, toward WEST NEWTON 0.4mi
Turn SLIGHT RIGHT onto WASHINGTON ST/MA-16 East 0.3mi
Continue following WASHINGTON ST, takes you in circle over MASS PIKE
Stay straight to go onto ELM STREET 0.3mi
TAKE 3RD Left on RIVER STREET 0.6mi
River STREET becomes RUMFORD AVE. 0.1mi
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Directions coming from the West:

Take I-90 East/MASS PIKE/MASSACHUSETTS
Take I-95 North-30/Route-128 North exit, EXIT 14, toward N.H.-MAINE/POINTS NORTH
1.2mi
Merge onto MA-30 via EXIT 24 toward NEWTON/BOSTON 1.0mi
Turn LEFT onto LEXINGTON STREET 0.8mi
Turn LEFT onto RUMFORD AVE. 0.1mi
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PATIENT REGISTRATION

Boston Osteopathic Health

134 Rumford Ave, Suite 208
Newton, MA 02466
Tel. 617-431-4451 Fax. 617-431-4456

TODAY'S DATE _____ / _____ / _____

Personal Information

Last Name	_____	Birthdate	_____ / _____ / _____	Age	_____
First Name	_____	Occupation	_____		
Home Address	_____		Employer Name	_____	
City/State/Zip	_____		Employer Address	_____	
Preferred Phone #	_____		Secondary Phone #	_____	

How would you prefer to be addressed? _____

Student? NO / YES, FT / YES, PT

How did you hear about Boston Osteopathic Health? _____

EMAIL ADDRESS: _____

Is patient's condition related to work? YES / NO. If yes, date of injury _____ / _____ / _____ Name of Employer: _____

Is patient's condition related to an auto accident? YES / NO If yes, date of injury: _____ / _____ / _____

MEDICARE OPT-OUT NOTIFICATION:

Dr. William Foley and Dr. Kristin Foley are not contracted with Medicare. You agree by signing below not to request that Boston Osteopathic Health submit a claim for payment to Medicare for services. You also understand that no reimbursement will be provided by Medicare for services provided and that other supplemental insurance plans may or may not choose not to make payment for services furnished by physicians not participating with Medicare.

In Case of an Emergency

Name	_____	Relationship	_____	
Address	_____		Phone Number	_____
City/State/Zip	_____			

I hereby certify that the above information is true and correct to the best of my knowledge.

Printed (Patient/Parent/Guardian)

Signature

Date



Cancellation Policy

Please let us know if you are not able to keep your scheduled appointment. We require 2 business days for cancellation.

- Cancellations made 2 business days or more before the appointment will not be charged.
- Cancellations made less than 2 business days will be charged \$50.
- Cancellations made less than 24 hours will be charged half the cost of the appointment.
- Appointments missed without notification will be charged the full cost of the appointment.

Please be aware that these charges are not billable to any insurance company; you have to pay them yourself.

Of course, if you have a true emergency, (such as an injury or significant illness) we will waive the charge.

We will understand if you show up late, but please know that we have to end on time so that we are not cutting into someone else's time.

I have read and understand the above policy:

Name: _____

Date: _____

Signature: _____



134 Rumford Avenue, Suite 208, Newton MA 02466

Health Information Consent

I give my consent to representatives of Boston Osteopathic Health to leave messages on my personal answering machine or with individuals that I designate below.

Relating to my care ___ Yes ___ No

Appointment reminders ___ Yes ___ No

I give consent to representatives of Boston Osteopathic Health to discuss my care with the following individuals:

_____	(____) _____
Spouse Name	Phone number
_____	(____) _____
Family member/ Relationship	Phone number
_____	(____) _____
Family member/ Relationship	Phone number
_____	(____) _____
Other/ Relationship	Phone number

I understand and agree that this authorization will stay in effect until I notify Boston Osteopathic Health with written notice to change or withdraw my authorization.

Signature _____ Date _____

Notice of Privacy Policies-Acknowledgement of Review

I have reviewed the Notice of Privacy Policies for Boston Osteopathic Health that explains my rights and documents policies and procedures that will safeguard my private health information.

Signature _____ Date _____

BOSTON OSTEOPATHIC HEALTH

Initial Office Visit/OMM consultation

Date: _____

Patient Name: _____

DOB: _____

Primary care physician: _____

Occupation: _____

Referred by _____ for an osteopathic manipulative medicine consultation for below chief complaint.

Subjective:

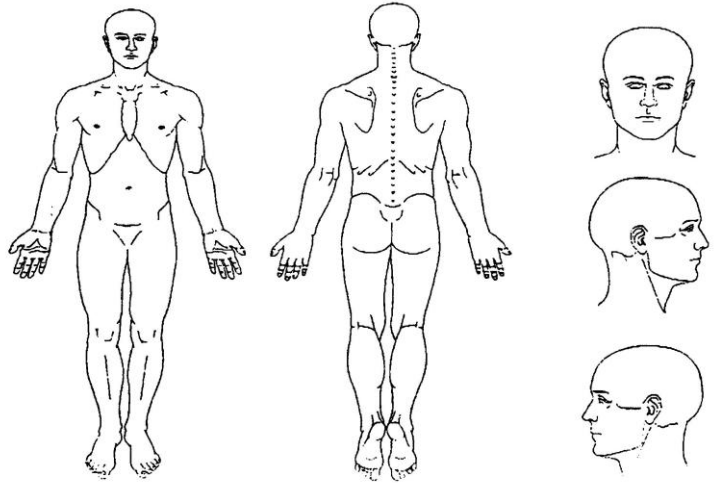
Main Concern (chief complaint): _____

HPI: Onset/duration: _____ Location: _____

Description/quality: _____ Pain score: 0 1 2 3 4 5 6 7 8 9 10 _____

Gets better with: _____ Gets worse with: _____

Trauma/mechanism of injury: _____



you may draw on the diagrams to illustrate symptoms

BOSTON OSTEOPATHIC HEALTH

Patient Name: _____

Date: _____

Medical history: *list any current or past medical diagnoses*

Surgical history:

Medications: _____

Vitamins/supplements: _____

Allergies: (Drug, food, contact, seasonal): _____

Obstetrical history: How many pregnancies? _____ How many children do you have? _____

Trauma history: _____

Social history: Tobacco: y/n _____ Alcohol: y/n _____ Drugs: y/n _____ Caffeine: y/n _____ Daycare/school: y/n _____

Family history: Mother: _____ Father: _____ Siblings: _____

ROS: *circle any chronic or current symptoms, the remainder is negative*

Fatigue, weight loss, insomnia, blurry vision, change in vision, poor vision, ear pain, hearing loss, throat pain, hoarseness, sinus pain, nasal congestion, cough, shortness of breath, wheezing, chest pain, palpitations, nausea, vomiting, diarrhea, constipation, bloating, abdominal pain, acid reflux, urinary burning, incontinence, joint pain, muscle pain, headache, numbness, tingling, dizziness, muscle weakness, bruising, bleeding, hair loss, dry skin, intolerance to heat /cold, hot flashes, depression, anxiety, allergy to drug/environment/food

Physical Exam:

BP _____ Pulse _____ RR _____ Temp _____ Height _____ Weight _____ Pain _____

Appearance: _____ Chest _____

Head: _____ Eyes: _____

ENT: _____ Endo: _____

Cardiac: _____ Resp: _____

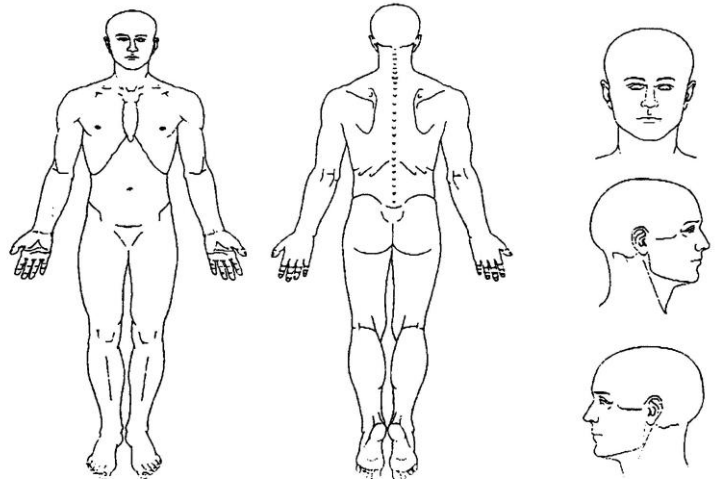
Abd: _____ Lymph: _____

Neuro: _____

Extremities: _____

Skin: _____

Musculoskeletal/osteopathic structural:



BOSTON OSTEOPATHIC HEALTH

Patient Name: _____

Date: _____

Region	Comments	A r t	B L T	C S	F P R	H V L A	M E	M F R	O C F	P H	S T	V i s	o t h
Head	OA SS R / L												
Neck													
Thoracic													
Lumbar													
Sacrum	SI Restricted R / L												
Pelvis	Innominate ant / pos R / L												
Lower ext													
Upper ext													
Rib													
Abd													

Assessment:

ICD9 code	Diagnosis	ICD9 code	Diagnosis
		739.0	Head
		739.1	Cervical
		739.2	Thoracic
		739.3	Lumbar
		739.4	Sacrum
		739.5	Pelvis
		739.6	Lower extremity
		739.7	Upper extremity
		739.8	Ribs
		739.9	Abdomen/other

Plan:

OMT discussed with patient/guardian including risks and benefits and consent was obtained for a trial for OMT.
 OMT performed as above: 1-2 areas 3-4 areas 5-6 areas 7-8 areas 9-10 areas
 OMT was tolerated well/poorly. *Visit length (in minutes) ≥ 10 20 30 45 60

The patient had: improved motion, decrease restriction, less pain, decreased symptoms after treatment.

Osteopathic treatment was directed not only to the primary area of complaint, but also the secondary, biomechanical compensatory pattern associated with the primary area.

**Patient was counseled for _____ minutes regarding _____

Reevaluate and consider further treatment options in _____ Days _____ Wks _____ Mos _____ PRN

Physician: _____

Date: _____