



**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  
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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 3<sup>RD</sup> Left on RIVER STREET 0.6mi  
River STREET becomes RUMFORD AVE. 0.1mi  
\*\*\*Turn Right into first drive (PACARD COVE OFFICE PARK).  
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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 #	_____	
Cell	_____	Work	_____	Home	_____
	_____	Other	_____	Cell	_____
	_____		_____	Work	_____
	_____		_____	Home	_____
	_____		_____	Other	_____

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

**Boston Osteopathic Health (BOH)**  
**Consent for Osteopathic Manipulative Treatment (OMT)**

Please be sure you have read and understand the following information before signing this consent. If you have any questions, allow us to answer them to your satisfaction before giving your consent for treatment.

**What is OMT?**

OMT is a non-invasive manual medicine treatment that focuses on total body health by treating and strengthening the musculoskeletal framework including the joints, muscles, and spine. Its aim is to positively affect the body's nervous, circulatory, and lymphatic systems. This treatment is a holistic (whole body) approach to health care. Osteopaths do not simply concentrate on treating the problem area, but use manual techniques to balance all the systems of the body, to provide overall good health and wellbeing. As this is a hands on treatment, your osteopath will likely touch areas of your body including, but not limited to, your head, spine, pelvis, tailbone, coccyx, and limbs.

**Benefits of Osteopathy**

Potential benefits of OMT include reduction of pain or discomfort, greater flexibility and strength, restoration of symmetry, improvement in numbness or tingling, reduction of swelling, enhancement of the body's natural healing mechanisms, and improvement in function of the body's organs systems.

**Possible Side Effects**

OMT is generally very safe, well received, and painless, without complication. Mild soreness lasting 3-7 days after treatment is possible, and is usually considered a normal part of the healing process. Most commonly drowsiness, headache, or lightheaded feeling may occur temporarily. Training prepares osteopaths to examine and screen for potential difficulties that indicate where certain techniques should not be used, thereby avoiding patients being exposed to unnecessary risk. Serious side effects (fracture, disc herniation, and blood vessel injury) are extremely rare – they have been reported as occurring in between 1 in 400,000 to 1 in 5.85 million patients undergoing cervical spine high velocity thrusting manipulation. In comparison, NSAIDS, such as Advil, have an estimated risk of serious side effects (e.g. peptic ulcer or death) of 1 in 1000 patients. As in any form of medicine, unexpected risks or complications may occur. If, during the course of treatment, unforeseen conditions are discovered it may be necessary to alter or discontinue osteopathic manipulative treatment.

**Acknowledgment**

I acknowledge that I have read the above description about OMT, and understand possible risks and benefits of the OMT. I have informed the physician of any previously diagnosed conditions that may affect the treatment outcome. I am informed that BOH will not be providing routine internal medicine care for me and I am advised to have a primary care provider to provide my acute and chronic medical care. I understand that there is no guarantee that OMT will resolve my symptoms. I consent to the performance of OMT by the BOH physicians.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ 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: \_\_\_\_\_

\_\_\_\_\_

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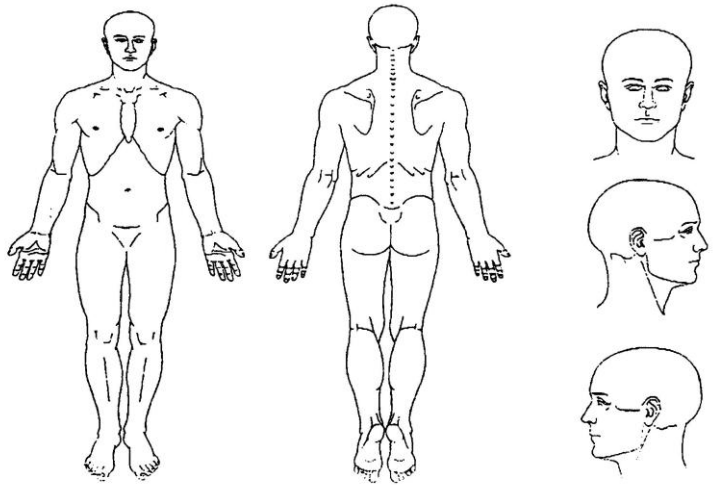
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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: \_\_\_\_\_

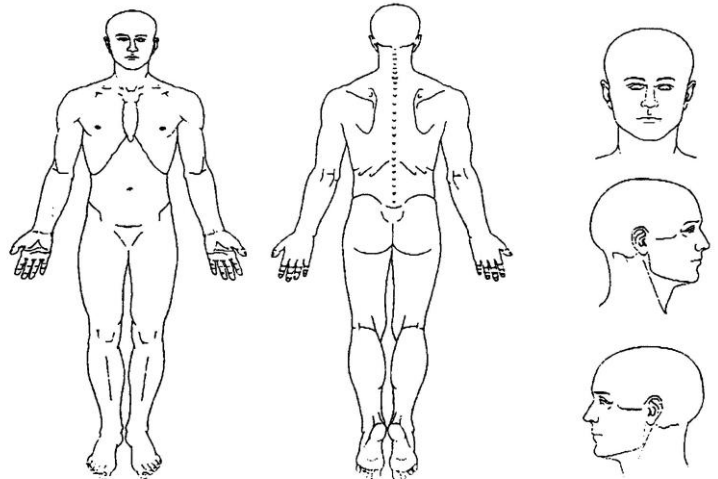
Neuro: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Musculoskeletal/osteopathic structural:

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# 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: \_\_\_\_\_