☐ Andrew Braziel, MD ☐ Alan Curtis, MD ☐ Kurt Hofmann, MD
☐ Andrew Jawa, MD ☐ Hervey Kimball, MD ☐ Brian McKeon, MD
☐ Suzanne Miller, MD ☐ Kai Mithoefer, MD ☐ John Richmond, MD
☐ Mark Slovenkai, MD ☐ Andrew Terrono, MD ☐ Paul Weitzel, MD
☐ Thomas Wuerz, MD
☐ Irene Ghobrial, PA-C ☐ Sheri Martinelli, PA-C ☐ Thomas Pacheco, PA-C
☐ Jason Rand, PA-C ☐ Sarah Rice, PA-C ☐ Stephen Wright, PA-C

BSSC
Boston Sports & Shoulder Center

*****Please complete the enclosed paperwork and bring it with you to your appointment.*****

Dear

We look forward to seeing you at your appointment on:

_____ (arrive 30 minutes early for x-rays, if needed)

Location:

☐ Boston ☐ Bourne ☐ Braintree ☐ Dedham ☐ Waltham

In addition to this paperwork, please bring your insurance card, a government issued photo ID, insurance referral if required by your insurance plan, any medical records, MRIs, x-rays, and your co-payment. We ask that you call your insurance company to verify your coverage and benefits. Please arrive 30 minutes early if you require x-rays. Please dress appropriately for your appointment. Appropriate attire should allow easy access to the injured area (i.e. for knee injuries wear shorts, shoulder injuries wear a t-shirt or tank top etc).

Please be advised that your referral and co-payment, if required, are due at the time of your visit. *There will be no exceptions to this policy.* **If we do not have a referral from your primary care physician upon check-in, you will be required to pay a $150.00 deposit in order to be seen for your appointment.** Please contact your PCP ASAP as it can take up to 7-10 business days for them to process your referral. Upon receipt of your referral, we will bill your insurance carrier. Once we receive payment from your insurance carrier, we will refund the deposit to you less any patient balance. ***If you have not disclosed that this was a work or auto-related injury and your medical insurance denies payment, you will be 100% responsible for any and all bills incurred.***

Please take the time to register for our patient portal which is available at our website: **www.bostonssc.com**. Once registered, you can view upcoming appointments, view billing statements and certain medical records, make secure credit card payments, request prescription refills, and communicate directly with our staff.

If you have any questions, please feel free to give us a call. Thank you!

Sincerely,

Boston Sports & Shoulder Center

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

Boston Sports and Shoulder Center

PATIENT REGISTRATION - Account#
****Please verify your information and document any changes for our records. Thank you!****

Patient Last Name:	*Patient First Name:*	*M.I.:*
Address:		
City:	*State:*	*Zip:*
DOB:	*Age:*	*Gender:*
Marital Status:		
Home Phone:	*Work Phone:*	*Cell Phone:*
Email:		
Employer:	*Address:*	
Emergency Contact Name:	*Phone:*	
Responsible Party Name/Relationship:	*Address/Phone:*	
Primary Care Physician: First Name:	*Last Name:*	
PRIMARY INSURANCE INFORMATION: This information is required		
Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other:		
Insurance Company:	*Name of Insured:*	
Insured's Date of Birth:	*Gender (M / F):*	
Insured's ID Number:	*Group Policy Number:*	
Insured's Address (if different from patient's):	*Phone:*	
***SECONDARY INSURANCE INFORMATION**:*		
Insurance Company:	*Name of Insured:*	
Insured's Date of Birth:	*Insured's ID Number:*	*Insured's SSN:*
Address:	*Effective Date:*	
***Tricare/Tricare of Life**: Effective Date:*	*Expiration Date:*	*Status:*
Sponsor's Date of Birth:	*Sponsor's SSN:*	*Service/Rank:*

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Boston Sports and Shoulder Center.
I authorize the release of any medical records for treatment, payment or healthcare operations.

INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM. FURTHER, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE.

Authorized Signature: _____ Date: _____

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

BOSTON SPORTS & SHOULDER CENTER **MEDICAL HISTORY FORM -1**

Account #: **Date:** _____

Patient Name:	DOB:	Sex:	Age:	Height:	Weight:

Primary Care Physician (First & Last Name): **Address:**	**Referred to this office by:**	**Your Occupation:**

What is the reason for your visit today?_____

Which side is affected? ☐ **Right** ☐ **Left** ☐ **Both** **If both, which is worse?** ☐ **Right** ☐ **Left**

Which hand is dominant? ☐ **Right** ☐ **Left**

Date of injury:_____ **OR** **No injury, date of onset of symptoms:**_____

What activity were you doing when the problem began?_____

Where were you participating in this activity?_____

Have you been evaluated or treated for this injury/condition?

☐ **No**

☐ **Yes. What is the diagnosis you were given?**_____

Have any treatments been done for this problem? (e.g. physical therapy, injections)

_____

What makes it better?

_____

What makes it worse?

_____

At night is it? ☐ **Better** ☐ **Worse** ☐ **No Change**

Describe the pain (if present) / location:

_____

Have you ever had similar symptoms? ☐ **No** ☐ **Yes. If yes, when?** _____

Is this an injury that occurred at work? ☐ **No** ☐ **Yes. Date of injury:**_____

Is this injury/condition a result of your employment? ☐ **No** ☐ **Yes**

Is this related to an auto accident? ☐ **No** ☐ **Yes. Date of accident:**_____

Have any tests been done for this problem? ☐ No test was done ☐ X-ray ☐ CT Scan ☐ MRI ☐ EMG

☐ Other: (Please describe)_____

Please provide dates and location:

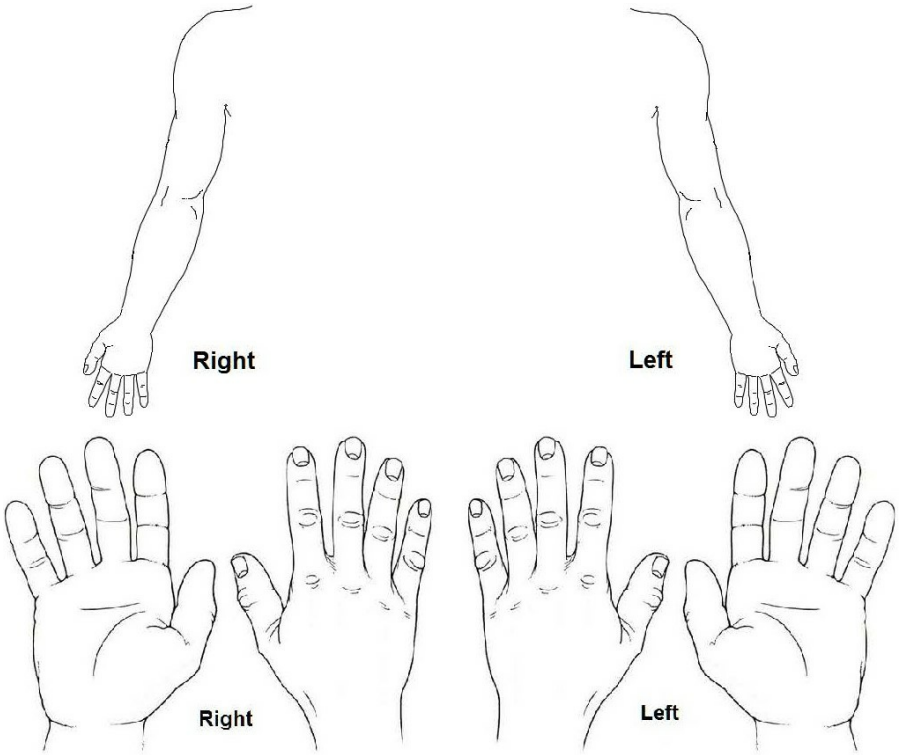
Is this condition/problem affecting your ability to exercise or perform activities of daily living?

☐ No ☐ Yes. Please explain:_____

BOSTON SPORTS & SHOULDER CENTER **MEDICAL HISTORY FORM -2**

Account #: **Date: _____**

Please mark the areas of pain, tingling, numbness (no sensation) and decreased sensation.
Pain XXXXXX Tingling ..... Numbness ###### Decreased Sensation ////////



Do you smoke? ☐ No ☐ Yes. How many per day?_____
Do you Vape or use an E-Cigarette? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes. How much per week?_____

Have you had the flu vaccine? ☐ No ☐ Yes. If yes, when?_____
Have you had the pneumococcal vaccine? ☐ No ☐ Yes. If yes, when?_____

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ **State:**_____ **Pharmacy Phone Number:**_____

Please list all medications you are currently taking with dosage (prescription/non-prescription)

Please list all allergies (drug and non-drug related, and reactions)

List all past surgeries:

Date:	Type of Surgery

BOSTON SPORTS & SHOULDER CENTER
Account#

MEDICAL HISTORY FORM-3
Date:_____

Patient Name:	DOB:	Sex:	Age:	Height:	Weight:

Please choose yes or no to indicate whether you have had or presently suffer from any of the following:

Angina, Heart Failure or Attack	☐ No ☐ Yes:	
Asthma / Shortness of Breath	☐ No ☐ Yes:	
Bleeding Disorder	☐ No ☐ Yes:	
Blood Clots/Phlebitis	☐ No ☐ Yes:	☐ Family Member _____
Cancer / Location(s)	☐ No ☐ Yes:	
Chemical Dependency / Alcoholism	☐ No ☐ Yes:	
Depression or Anxiety	☐ No ☐ Yes:	
Diabetes	☐ No ☐ Yes:	☐ Type I ☐ Type II
Emphysema/Chronic Bronchitis	☐ No ☐ Yes:	
Hearing Loss	☐ No ☐ Yes:	
Heart Disease	☐ No ☐ Yes:	
Hepatitis / Jaundice	☐ No ☐ Yes:	
High Blood Pressure (Hypertension)	☐ No ☐ Yes:	
HIV or AIDS	☐ No ☐ Yes:	
Irregular Heartbeat or Heart Problems	☐ No ☐ Yes:	
Kidney / Bladder Infections	☐ No ☐ Yes:	
MRSA (history of/previously had)	☐ No ☐ Yes:	
Night Sweats	☐ No ☐ Yes:	
Osteoarthritis / Rheumatoid arthritis / Other [Please Circle Which Applies]	☐ No ☐ Yes:	
Psoriasis / Skin Rash	☐ No ☐ Yes:	
Pulmonary Embolism	☐ No ☐ Yes:	
Reaction to General/Local Anesthesia	☐ No ☐ Yes:	☐ Family Member _____
Seizures / Epilepsy	☐ No ☐ Yes:	
Stroke	☐ No ☐ Yes:	
Thyroid Disorder	☐ No ☐ Yes:	
Ulcer / Stomach Bleeding / Indigestion	☐ No ☐ Yes:	
Visual Loss or Glaucoma	☐ No ☐ Yes:	
Weight Gain / Loss	☐ No ☐ Yes:	
Any Other Significant Medical Issues	☐ No ☐ Yes:	

Patient Signature

Physician Signature

Account#

BOSTON SPORTS AND SHOULDER CENTER'S NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF PATIENT PRIVACY PRACTICES.

INTRODUCTION

At Boston Sports & Shoulder Center, we are committed to treating and using your protected health information (PHI) responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice of Patient Privacy Practices is effective February 1st , 2006, and it applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Boston Sports & Shoulder Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the Commonwealth and the nation;
- A source of data for our planning and marketing;
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding the information in your health record and how your protected health information is used helps you to ensure its accuracy; to better understand who, what, when, where, and why others may access your protected health information; and to make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Boston Sports & Shoulder Center, the information belongs to you. Therefore, you have the right to:

- Obtain a paper copy of this Notice of Patient Privacy Practices upon request;
- Inspect and copy your health record as provided for in 45 CFR 164.524;
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your protected health information as provided in 45 CFR 164.528;
- Request communications of your protected health information by alternative means or alternative locations;
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522; and
- Revoke your authorization to use or disclose protected health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Boston Sports & Shoulder Center is required to:

- Maintain the privacy of your health information;
- Provide you with this Notice of Patient Privacy Practices;
- Abide by the terms of this Notice of Patient Privacy Practices;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate your reasonable requests to communicate your protected health information by alternative means or at alternative locations.

In the event that you suspect Boston Sports and Shoulder Center has compromised your protected health information, you are urged to immediately contact the following:

Shannon Martin
Boston Sports & Shoulder Center
Privacy and Security Officer
Phone: (857) 293-9837
Email: shannonmartinhipaa@outlook.com
Web Site: www.bostonssc.com

U.S. Department of Health & Human Services
Region I- (CT, ME, MA, NH, RI, VT)
Susan Rhodes, Regional Manager, Office for
Civil Rights
U.S. Department of Health and Human Services
Government Center
John F. Kennedy Federal Building Room 1875
Boston, Massachusetts 02203
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Boston Sports and Shoulder Center reserves the right to change this Notice of Patient Privacy Practices and to enforce the new provisions for all protected health information we maintain. Should our information practices change, we will provide you with a revised notice by mail, electronic mail, or in-person at Boston Sports and Shoulder Center's Waltham location and/ or Boston Sports and Shoulder Center's Dedham location. Boston Sports and Shoulder Center will not use or disclose your protected health information without your authorization, except as described in this Notice of Patient Privacy Practices. Boston Sports and Shoulder Center will also discontinue use or disclosure of your protected health information after we have received a written revocation of the Authorization to Use and Disclose Patient Information according to the procedure included in the Authorization.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Patient Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature of Patient or Legally Authorized Representative	Date
Patient Name (Please Print)	Patient DOB
Name of Legally Authorized Representative (Please print)	Authority of Legally Authorized Representative

BOSTON SPORTS & SHOULDER CENTER
Account#

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of Boston Sports & Shoulder Center, you have the right to know how we may use and disclose information about you. Information about our disclosures is provided in our **Notice of Patient Privacy Practices** and a copy of this notice has been provided to you. You have the right to review our notice before signing this form. You should read our Notice carefully before signing this form. As our Notice of Patient Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations. Your Protected Health Information (PHI) by law, is available to other treating providers such as your primary care physician or your physical therapist and also to your insurance company. **If you would not like to disclose your PHI** to any person(s) other than another treating provider or insurance company, please choose that option below**If you would like your PHI to be available** to a family member, employer, personal trainer etc, please provide their information below.

Please choose and initial either option (1) or option (2) below:

1. I **do not authorize** disclosure of my Protected Health Information to any entity other than for the purposes of treatment, payment, or normal healthcare operations. _____

2. I **do authorize** the use and disclosure of the following types of Protected Health Information that may pertain to any health care I have received to date:
   _____ My entire medical record _____ Only Information related to _____

   2a. I authorize the use and disclosure of my Protected Health Information for the following purpose(s):

   _____

   2b. I authorize my Protected Health Information to be disclosed to:

   Name _____ Relationship: _____

   Name _____ Relationship: _____

I HAVE BEEN TOLD THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I agree that this authorization for use and disclosure of my identifiable health information will be effective from the date I sign this document until this authorization expires or until I revoke this authorization. I understand that I may revoke this authorization at any time by giving Boston Sports & Shoulder Center notice in writing at 840 Winter Street, Waltham MA 02451. I also understand that treatment, payment, enrollment in a health plan, or eligibility for certain health benefits cannot be conditioned on my providing this authorization.

By signing below I agree that my Protected Health Information may be used or disclosed as described above

Signature of Patient or Legally Authorized Representative	Date
Patient Name (Please Print)	Patient DOB
Name of Legally Authorized Representative (Please print)	Authority of Legally Authorized Representative

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

BOSTON SPORTS & SHOULDER CENTER **BILLING POLICY**
Account#

HEALTH INSURANCE CARD: Please have this with you when you register with our staff. If your insurance should change, please notify the office as soon as possible.

INSURANCE BENEFIT: It is your responsibility to verify your medical benefit with the insurance company. BSSC will also verify it only as a courtesy. Any information provided to us by the insurance company at the time of verification does not guarantee payment and the benefit is subject to the provision of your policy at the time when insurance company processes your claims.

REFERRALS: If your insurance policy requires referrals, you are responsible to provide one at the time of your visit, and to provide more as needed to continue your treatment. You must keep track of your visits and not exceed the number of visits authorized on the referral and not to go beyond the expiration date. You will be responsible for any visits that are not covered by referrals at the time of the visits.

MOTOR VEHICLE ACCIDENT AND OTHER THIRD PARTY LIABILITY CLAIMS: BSSC will not bill MVA insurance carriers or attorneys for services rendered. All visits are to be paid in full at the time of the visits. BSSC will assist you in obtaining payment from the insurance company by providing any necessary documentation at your request.

WORKER'S COMPENSATION: You need to provide us with your date of injury, claim number, case adjustor's name and telephone number at your first visit. We reserve the right to cancel your appointment until the worker's comp claim is verified and approved. ***If you have not disclosed that this was a work or auto-related injury and your medical insurance denies payment, you will be 100% responsible for any and all bills incurred.***

CONSENT TO RENDER PAYMENT: You hereby authorize the payment of medical benefits to BSSC for services rendered. BSSC agrees to bill your insurance company as a courtesy. However, should the insurance company delay payment, pend or deny claims beyond 60 days of submission, you will be responsible for payment in full to BSSC within 10 days of notification from insurance company or BSSC billing department.

DEDUCTIBLE AND CO-INSURANCE: You hereby agree to pay all the deductible and co-insurance payments, if required by your insurance policy, at the time of your visits. This is a contractual obligation with your insurance company and we are mandated to collect it from you. Please be aware that the exact amount of your deductible and co-insurance payments will be determined at the time your claims are processed. They might be different from what BSSC verified with your insurance company at the time of your visit as your benefit level can periodically change.

MEDICATION DOWNLOAD: BSSC utilizes electronic prescriptions and may access your medication history electronically. Electronically accessing your medication history allows us to receive critically important information on your current and past prescriptions and to become better informed about potential medication issues. We can use this information to improve safety and quality.

PATIENT CHART SHARE: As a requirement of Meaningful Use, Boston Sports and Shoulder Center must participate in a clinical data exchange program through CommonWell Network. Direct Data exchange may be used to connect healthcare providers and facilitates accurate communication between members of the patient's healthcare team. An example of information that may be shared includes demographics, diagnosis or allergies.

PATIENT STATEMENTS: All bills are payable within 30 days of receipt. You will be contacted via our automated messaging system when you have a balance due. Failure to respond to our patient statements after 60 days will result in your account being turned over to a collection agency and a $25.00 collection fee will be assessed. Your credit rating will be affected.

I have read the billing policy and I fully understand my responsibilities as a patient.

Signature of Patient or Legally Authorized Representative

Date

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

BOSTON SPORTS & SHOULDER CENTER
Account#

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to: the use or disclosure of my "protected health information" (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and this Consent by Boston Sports and Shoulder Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Boston Sports and Shoulder Center. I understand that diagnosis or treatment of me by the physician(s) and/ or physical assistant(s) and/ or medical assistant(s) at Boston Sports and Shoulder Center may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my physician, physician assistant, medical assistant, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the healthcare operations of Boston Sports and Shoulder Center. Boston Sports and Shoulder Center is not required to agree to any restriction that I may request. If, however, Boston Sports and Shoulder Center agrees to any restriction requested by me, such restriction shall be binding on Boston Sports and Shoulder Center and the physician(s) and/ or physical assistant(s) and/ or medical assistant(s) at Boston Sports and Shoulder Center. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Boston Sports and Shoulder Center and/ or the physician(s) and/ or physical assistant(s) and/ or medical assistant(s) at Boston Sports and Shoulder Center have taken action in reliance on this Consent.

I understand that I have a right to review Boston Sports and Shoulder Center's **Notice of Patient Privacy Practices** prior to signing this Consent. Boston Sports and Shoulder Center's Notice of Patient Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of the health care operations of Boston Sports and Shoulder Center. This Notice of Patient Privacy Practices also describes my rights and Boston Sports and Shoulder Center's duties with respect to my protected health information.

Please also note that as provided in Boston Sports and Shoulder Center's Notice of Patient Privacy Practices, Boston Sports and Shoulder Center reserves the right to change the privacy practices that are described in such notice. I may obtain a revised Notice of Patient Privacy Practices by calling the Boston Sports and Shoulder Center's Waltham office at (781) 890-2133, or, Boston Sports and Shoulder Center's Dedham office at (617) 264-1100 and requesting a revised copy be mailed to the location of my choice, or by asking for one at the time of my next appointment.

Signature of Patient or Legally Authorized Representative	Date
Patient Name (Please Print)	Patient DOB
Name of Legally Authorized Representative (Please print)	Authority of Legally Authorized Representative

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

BOSTON SPORTS AND SHOULDER CENTER (BSSC) PRESCRIPTION DRUG POLICY

Dear

Many patients require prescription medication for pain management during the treatment of an orthopedic problem or condition. BSSC wishes to advise you of the practice's desire to provide medication(s) to assist with pain control in compliance with existing medical guidelines and Massachusetts law.

BSSC may provide a prescription for pain control, if needed, after surgery and/or an acute injury. After this time period, if you still require such medication(s), you will be referred to your primary care practitioner or a pain management specialist for further treatment.

We request that you inform your BSSC provider if you have received a prescription for narcotic pain medication within the last month and/or are under the care of another practitioner for chronic pain management. Failure to disclose this information may result in discharge from BSSC.

Medication refill requests must be made via the prescription refill line. Messages must be left on the prescription line by 3pm, Monday thru Friday. All messages will be verified with your provider and you will be notified of approval or denial within two business days. Narcotic prescriptions will not be called into your pharmacy or sent via overnight mail. It is your responsibility to arrange for the pick-up of necessary prescriptions.

The following is important information regarding BSSC prescriptions:

- One physician/physician assistant will manage your narcotic medications.
- First-time narcotic prescriptions are limited, by law, to a maximum of a 7-day supply.
- Prescriptions will not be refilled early.
- BSSC will not refill prescriptions that are lost.
- BSSC cannot refill prescriptions that are stolen without a police report.
- Online pharmacy checks may be utilized to verify prescription usage.

We regret the need to have such a stringent policy however the changing face of medicine necessitates these actions. By signing this, you are acknowledging Boston Sports & Shoulder's Prescription Drug Policy.

Signature of Patient or Legally Authorized Representative	Date
Patient Name (Please Print)	Patient DOB
Name of Legally Authorized Representative (Please print)	Authority of Legally Authorized Representative

BOSTON SPORTS & SHOULDER CENTER **DEMOGRAPHIC INFORMATION**
Account#

Boston Sports and Shoulder Center is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs, but it will also improve the quality of your care and our ability to communicate with you, our patients.

As part of this program, the government requires us to record the following demographic information about you:

ü Preferred language ü Race ü Ethnicity ü Date of birth ü Gender

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Please identify your Race from the following CDC-defined options:

African	Dominican	Native Hawaiian
African American	European	Nepalese
Alaska Native	Filipino	Okinawan
American Indian	Haitian	Other Pacific Islander
American Indian or Alaska Native	Hmong	Other Race
Arab	Indonesian	Pakistani
Asian	Iwo Jiman	Polynesian
Asian Indian	Jamaican	Singaporean
Bahamian	Japanese	Sri Lankan
Bangladeshi	Korean	Taiwanese
Barbadian	Laotian	Thai
Bhutanese	Madagascar	Tobagoan
Black	Malaysian	Trinidadian
Black or African American	Maldivian	Vietnamese
Burmese	Melanesian	West Indian
Cambodian	Micronesian	White
Chinese	Middle Eastern or North African	Declined
Dominica Islander		

Please identify your Ethnicity from the following CDC-defined options:

Central AmericanCentral American Cuban Dominican Hispanic or Latino/Spanish

Latin American/Latin, LatinoLatin American/Latin, Latino Mexican Not Hispanic or Latino Puerto Rican

South American Spaniard Declined

Preferred Language: _____

40 ALLIED DRIVE, SUITE 102, DEDHAM, MA 02026 TEL 617. 264.1100 FAX 617. 264.1101
840 WINTER STREET, WALTHAM, MA 02451 TEL 781. 890.2133 FAX 781. 890.2177

BOSTON SPORTS & SHOULDER CENTER LOCATIONS AND DIRECTIONS

840 Winter St, Waltham, MA 02451 Ph: (781) 890-2133 F: (781) 890-2177

From I-95/128:

- **If coming from the south,** take exit 27A/B, then follow signs for exit 27B, at the end of the ramp, take a right
- Continue over the overpass and straight through the 1st set of lights, staying in the far right lane
- **If coming from the north,** take exit 27B - Wyman Street/Winter Street, stay in far right hand lane at the end of the exit ramp
- Pass a reservoir on the right, continuing as the road takes a sharp bend to the right
- When the road straightens, there will be a stone sign on the left that reads 840 Winter Street/Waltham Woods/Healthpoint
- Take a left into this main entrance then your your second left, following the signs toward #840/Healthpoint
- Our office is located inside of the Boston Sports Club, to the left of the main desk.

40 Allied Dr, Dedham MA 02026 Ph: (617) 264-1100 F: (617) 264-1101

From I-95S

- Take exit **14** toward **East St/Canton St**
- At the traffic circle, take the **5th** exit onto Allied Dr
- Destination will be on the left

From I-95N

- Take exit **14** toward **East St/Canton St**
- At the traffic circle, take the **2nd** exit onto Allied Dr
- Destination will be on the left

125 Parker Hill Avenue, Boston, MA 02120 Ph: (617) 264-1100 F: (617) 264-1101

If you are coming from the north take I-95 S and I-93 S

- Follow US-1 South to merge onto I-95S
- Follow I-95 S and I-93 S to Massachusetts Ave Connector in Boston. Take exit 18 from I-93 S
- Continue on I-95 S
- Take exit 37A to merge onto I-93 S toward Boston
- Continue on 1-93 S
- Take exit 18 toward Roxbury/Andrew Sq/Mass Ave - Continue on Mass Ave until Parker Hill Avenue

If you are coming from the south take I-495 N, MA-24 N and I-95 N

- Take MA-28 N to get onto I-495 N/MA-25 E
- Take I-495 N, MA-24 N and I-95 N to MA-9 E/Rte 9 E in Norfolk County. Take the Rte 9 exit from I-95 N.
- Merge onto I-195 E
- Take exit 22B toward I-495 N/Marlboro and merge onto I-495 N
- Take exit 7A to merge onto MA-24 N toward Boston, and then use the left 2 lanes to take exit 21B for Interstate 93 S toward Interstate 95
- Merge onto I-93 S and continue to US 1 S and I-95 N.
- Exit onto MA Route 9 East and follow Route 9 East until Parker Hill Avenue.

250 Pond Street, Braintree, MA 02184 Ph: (617) 264-1100 F: (617) 264-1101

If you are coming from the north take I-95S and I-93 N

- Follow US-3 South to merge onto I-95 S
- Take exit 25B to merge onto I-95 S towards Providence, RI
- Continue onto US-1 N and then I-93 N
- Take exit 6 to merge onto MA-37 S toward Braintree
- Follow MA-37 S onto Granite Street
- Turn left onto Town Street
- Turn left onto Pond Street - and turn into HealthSouth Braintree Rehab Hospital

If you are coming from the south take I-495 N and MA-24 N

- Take 495-N toward Taunton/Marlboro
- Take exit 7A off 495-N onto MA-24N toward Boston
- Take exit 20A onto MA-139 E toward Randolph
- Turn left toward West Street and then turn right onto West Street
- Turn left onto North Main Street
- Turn right onto Allen Street
- Turn right onto Liberty Street
- Turn left onto North Street and continue until it turns into Pond Street
- Turn right to stay on Pond Street and turn into Healthsouth Braintree Rehabilitation Hospital.