617-431-4451

92 East Main Street
Westborough, MA 01581

134 Rumford Avenue
Suite 208
Newton, MA 02466

Dear New Patient,

Thank you for choosing Boston Osteopathic Health for your journey to better health. We are looking forward to meeting you.

Below you will find several forms containing registration information, informed consent, contact details, and the initial office visit. Please feel free to forward any other information pertinent to your situation that would be helpful for your doctor. Please complete all forms fully, except the initial office visit (only highlighted portions on page 1 and 2).

Please plan to arrive 15 minutes prior to your scheduled appointment to complete the registration process.

Please feel free to contact us with questions or concerns. We are pleased to become a new part of your healthcare experience.

Best Regards,

The Staff at Boston Osteopathic Health

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 (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_____

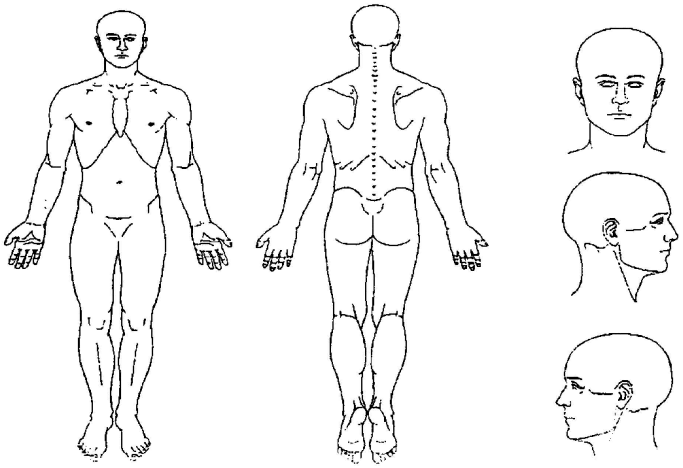
BOSTON OSTEOPATHIC HEALTH

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, change in vision, poor vision, ear pain, hearing loss, ear ringing, 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, muscle weakness, brain fog, dizziness, bruising, bleeding, hair loss, rash, 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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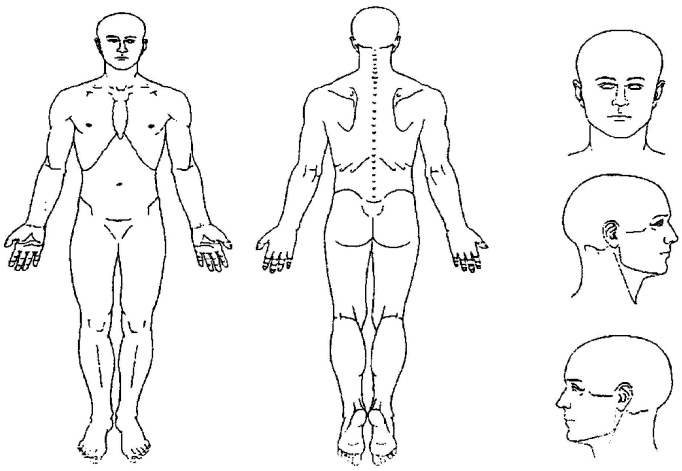

BOSTON OSTEOPATHIC HEALTH

Patient Name: _____ Date: _____

Region	Comments	Art	BLT	CS	FPR	HVLA	ME	MFR	OCF	PH	ST	Vis	oth
Head	OA E / F SS R / L, TMJ L / R, EV4, CV4, EV3												
Neck	C 1, 2, 3, 4, 5, 6, 7, PSM HT												
Thoracic	T 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 SM, PSM HT												
Lumbar	L 1, 2, 3, 4, 5, PSM HT												
Sacrum	SI Restricted R / L												
Pelvis	Innominate ant / pos / up / down / R / L, Pubes res / comp												
Lower ext	L / R TC, TN, CC, 3rd cun, IOM, Fib, Pat, Femur Prox / Dist												
Upper ext	L / R Clav, Scap, GH, IOM, carp, CMC, MCP, PIP, DIP												
Rib	L / R R1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12												
Abd	MFS PS, PU, Epi, RUQ, LUQ, RLQ, LLQ, LA Lymph Syphon, Shock Rel												

Assessment:

ICD-10 code	Diagnosis	ICD-10 code	Diagnosis
		M99.00	Head
		M99.01	Cervical
		M99.02	Thoracic
		M99.03	Lumbar
		M99.04	Sacrum
		M99.05	Pelvis
		M99.06	Lower extremity
		M99.07	Upper extremity
		M99.08	Ribs
		M99.09	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: _____

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

Update**: Cancellation Policy**

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

- Cancellations made less than 2 business days will incur a charge of 1/2 the doctor's service fee.
- Appointments missed without notification will be charged the full cost of the appointment.

Please be aware that these charges are not reimbursable to any insurance company.

Your secure credit card on file will be charged if this policy is violated.

I have read and understand the above policy:

Name: _____ **Date**: __/___/_____

Signature: _____

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