C. STEPHEN FOSTER, M.D., F.A.C.S., F.A.C.R.
Clinical Professor of Ophthalmology
Harvard Medical School
Ocular Immunology and Uveitis Foundation
Founder and President

STEPHEN D. ANESI, M.D.
Staff Physician
1440 Main Street, Suite 201
Waltham, Massachusetts 02451

Massachusetts Eye Research and Surgery Institution
Est. 2005

Dear New Patient,

We are pleased to welcome you to the Massachusetts Eye Research and Surgery Institution (MERSI). Included in this packet is billing policy information for you to read below, directions, a new patient survey, and a form for you to list the doctors you currently see, whom you wish consult letters to be sent. MERSI currently uses NextMD as a secure communication portal. Please be sure to register at the Front Desk when you check in.

For a list of hotels near our office in Waltham, please visit our website at www.mersi.com.

The doctors request all new patients complete a patient review of systems, as well as the new patient forms we have included in this packet. Please bring the completed forms to your appointment and arrive 15 minutes prior to your scheduled time to allow us to enter in the information. You may also fax the information to MERSI before your appointment at 781-647-1430. New patient appointments at MERSI are very thorough and your physician may order testing during your visit. Please allow ample time for your visit. It is not uncommon for complicated new patient appointments to last four hours or longer.

Please bring your insurance card with you to the appointment. We will be checking eligibility on your insurance in advance. If your insurance company requires you to have a referral, the referral must be in place by the time of your visit or insurance will not cover the visit and you will be required to pay for your visit that day. If we are out of your insurance network, then an out of network authorization will be needed in order for your insurance to cover the visit, if not you will be expected to again pay for your visit that day. If you have a deductible with your insurance plan that has not been met, our office policy requires that you pay the remaining amount of your deductible at the time of the visit not exceeding cost of visit.

If you do not have insurance or your insurance is inactive, you will be responsible for the costs of your visit on that day. The fee for the consultation with Dr. Foster or Dr. Anesi is $600. We also require an additional $250 for a deposit on for possible diagnostic testing. If no testing is needed, the $250 will be reimbursed at the end of the visit. However, if more testing is needed, the fee could exceed the $250 and the patient is responsible for the difference. If our physicians are out of network for your insurance and you have no out of network benefits then you will be responsible for payment for the consult plus testing will be expected at time of service.

We look forward to seeing you. If you have any questions, please do not hesitate to call. For your information, we do have coffee and tea available, a kids' waiting room, and wireless internet access.

Sincerely,

The MERSI Staff

Appointments: 781-891-6377 • Toll free: 866-353-6377 • Fax: 781-647-1430
Web: www.mersi.com, www.uveitis.org • Email: sfoster@mersi.com • sanesi@mersi.com

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Patient Name: ______________________________
Patient Phone Number: ______________ Date of Birth: ______________
Address: ______________________________
Email: ______________________________

Primary Care Doctor (mandatory)
Name: ______________________________
Address: ______________________________
City: ______________ State: ______________ Zip Code: ______________
Telephone Number: ______________ Fax Number: ______________

Referring Ophthalmologist
Name: ______________________________
Address: ______________________________
City: ______________ State: ______________ Zip Code: ______________
Telephone Number: ______________ Fax Number: ______________

Other Specialist or Doctors (ex: rheumatologist, dermatologist, hematologist, oncologist, etc.)
Name: ______________________________
Address: ______________________________
City: ______________ State: ______________ Zip Code: ______________
Telephone Number: ______________ Fax Number: ______________

Name: ______________________________
Address: ______________________________
City: ______________ State: ______________ Zip Code: ______________
Telephone Number: ______________ Fax Number: ______________

How did you hear about MERSI? Please mark below:

PCP___ Ophthalmologist ___ Optometrist ___ Mt. Auburn ___ MGH ____ Internet ___
Specialist ___ Insurance Company ___ Newspaper ___ Angie's List ___Other (specify) ___________
MERSI Patient _____ Patient's name______________________________
If you were referred by a patient, may we use your name in thanking him/her? Yes___ No___

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Patient Name: ____

Patient Phone Number: ____________________ Date of Birth: ____________________

Email: ____

Emergency Contact Information

Emergency Contact Name: ______________________________ DOB: ______________

Relationship: ____________________ Phone Number: ____________________

Pharmacy Information for Medication Refills

Pharmacy Name: ____

Pharmacy Address: ____

____

Pharmacy Phone Number: ____

MERSI Additional Demographics

Patient Name: ______________________________ DOB: ____________

Email: ____________________________________

Please select the most appropriate option for each of these:

Race

__ American Indian or Alaska Native
__ Asian
__ Black or African American
__ Native Hawaiian or other Pacific Islander
__ Other Race
__ Unknown/Not Reported
__ White

Ethnicity

__ Hispanic or Latino
__ Not Hispanic or Latino
__Unknown/Not Reported

Language

__ Arabic
__ Bulgarian
__ Cambodian
__ Central Khmer
__ Chinese
__ English
__ French
__ Haitian Creole
__ Hebrew
__ Hindi
__ Italian
__ Japanese
__ Korean
__ Polish
__ Portuguese
__ Russian
__ Somali
__ Spanish; Castilian
__ Swahili
__ Thai
__ Urdu
__ Vietnamese

MASSACHUSETTS EYE RESEARCH AND SURGERY INSTITUTION (MERSI)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO DISCLOSE HEALTH INFORMATION

Patient Name:____
(Last) **(First)** **(Middle)**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for MERSI.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby consent to MERSI disclosure of my medical information so that MERSI may treat me, seek payment from third parties for such treatment, and generally carry on MERSI's health care operations (e.g., planning or other administrative activities.) I also consent to MERSI's disclosure of my medical information to insurers and providers outside of MERSI, when necessary, so these providers may treat me, seek payment for that treatment, and generally carry on their own health care operations. I also consent MERSI's disclosure of my medical information on my home answering machine/voice mail at the number below. I also consent to MERSI's disclosure of my medical information to observers, trainees (medical school students and medical school graduates) and fellows (licensed physicians) volunteering and working at MERSI, consistent with the educational mission of MERSI. I also consent to MERSI's disclosure of my medical information for charitable fundraising purposes, including, but not limited to disclosures to Ocular Immunology and Uveitis Foundation, Inc. I also consent to MERSI's use and disclosure of my medical information for the purpose of medical research projects.

_________________________________ _______________
Signature of Patient **Date**

Telephone Number: (_____)_________________________

If the patient is a minor child or is otherwise incapacitated (physically or mentally), complete the following:

_________________________________ _____________________
Signature of Personal Representative **Description of Authority**

____
Date

Massachusetts Eye Research and Surgery Institution

Ocular Inflammatory Disease Review of Systems Questionnaire

This is a **confidential** survey. Please respond to all questions by circling the proper answer. Please bring with you to your appointment.

Name: ____

Date of Birth: _____________ **Reason for Visit**: ___________________________

FAMILY HISTORY: These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in your **family** had any of the following?

Cancer	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Allergies	**YES**	**NO**	
Arthritis or rheumatism	**YES**	**NO**	
Syphilis	**YES**	**NO**	
Tuberculosis	**YES**	**NO**	
Sickle cell disease or trait	**YES**	**NO**	
Lyme disease	**YES**	**NO**	
Gout	**YES**	**NO**	

Patient Name: ____

Has anyone in your **family** had medical problems listed below?

Eyes	**YES**	**NO**	
Skin	**YES**	**NO**	
Kidneys	**YES**	**NO**	
Lungs	**YES**	**NO**	
Stomach or bowel	**YES**	**NO**	
Nervous system or brain	**YES**	**NO**	

Your SOCIAL HISTORY:

Current job: ______________________ Employer: ______________________

Have you lived outside the U.S.A.?	YES	NO
If yes, where? ____		
Have you ever owned a dog?	YES	NO
Have you ever owned a cat?	YES	NO
Have you ever eaten raw meat or uncooked sausage?	YES	NO
Have you ever had unpasteurized milk or cheese?	YES	NO
Have you ever been exposed to sick animals?	YES	NO
Do you ever drink untreated stream, well or lake water?	YES	NO
Do you currently use tobacco products?	YES	NO
Have you ever used recreational drugs injected in the vein?	YES	NO
Have you ever had bisexual or homosexual relationships?	YES	NO
Do you currently take or have you taken birth control pills in the last 5 years?	YES	NO

Medications:

Are you allergic to any medications?	YES	NO
Please list all allergies, including medications: ____		
Please list **ALL EYE DROPS**:		

Drug Name	Dosage	Frequency/eye

Patient Name: ____

Medications: **LIST all Other MEDICATIONS**:

Drug Name	Dosage	Frequency

PAST Medical/Surgical HISTORY:

Please List all **Eye Conditions and Surgeries** with dates:

Eye Medical Condition and Eye Surgeries	Date

Patient Name: ____

Please list all other **Medical History:**

Medical Health Problems	Date

NonEye Surgeries	Date

Patient Name: ____________________________________

Have you ever been told that you have the following conditions?

Anemia (Low Blood Counts)	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Hepatitis	YES	NO
High Blood Pressure	YES	NO
Pleurisy	YES	NO
Pneumonia	YES	NO
Ulcers	YES	NO
Herpes (cold sores)	YES	NO
Chicken Pox	YES	NO
Shingles (Zoster)	YES	NO
German Measles (Rubella)	YES	NO
Measles (Rubeola)	YES	NO
Mumps	YES	NO
Chlamydia or Trachoma	YES	NO
Syphilis	YES	NO
Gonorrhea	YES	NO
Any other sexually transmitted disease	YES	NO
Tuberculosis (TB)	YES	NO
Leprosy	YES	NO
Leptospirosis	YES	NO
Lyme Disease	YES	NO
Histoplasmosis	YES	NO
Candida or Moniliasis	YES	NO
Coccidiomycosis	YES	NO
Sporotrichosis	YES	NO
Toxoplasmosis	YES	NO
Toxocariasis	YES	NO
Cysticercosis	YES	NO
Trichinosis	YES	NO
Whipple's Disease	YES	NO
AIDS	YES	NO

Have you ever been told that you have the following conditions?		
Hay Fever	**YES**	**NO**
Allergies	**YES**	**NO**
Vasculitis	**YES**	**NO**
Arthritis	**YES**	**NO**
Rheumatoid Arthritis	**YES**	**NO**
Lupus (Systemic Lupus Erythematosus)	**YES**	**NO**
Scleroderma	**YES**	**NO**

Have you ever had any of the following illnesses?

Reiter's Syndrome	**YES**	**NO**
Colitis	**YES**	**NO**
Crohn's Disease	**YES**	**NO**
Ulcerative Colitis	**YES**	**NO**
Behcet's Disease	**YES**	**NO**
Sarcoidosis	**YES**	**NO**
Ankylosing spondylitis	**YES**	**NO**
Erythema Nodosa	**YES**	**NO**

Have you ever had any of the following illnesses?

Temporal Arteritis	**YES**	**NO**
Multiple Sclerosis	**YES**	**NO**
Serpiginous Choroidopathy	**YES**	**NO**
Fuchs' Heterochoromic Ididocyclitis	**YES**	**NO**
Vogt-Koyanagi-Harada Syndrome	**YES**	**NO**

Have you had any of the following symptoms in the past year?
GENERAL HEALTH:

Chills	**YES**	**NO**
Fevers (persistent or recurrent)	**YES**	**NO**
Night Sweats	**YES**	**NO**
Fatigue (tire easily)	**YES**	**NO**
Poor Appetite	**YES**	**NO**
Unexplained Weight Loss	**YES**	**NO**
Do you Feel Sick	**YES**	**NO**

Patient Name: ____________________________________

Have you had any of the following symptoms in the past year?

HEAD:

Frequent or Severe Headaches	**YES**	**NO**
Fainting	**YES**	**NO**
Numbness or Tingling in your body	**YES**	**NO**
Paralysis in parts of your body	**YES**	**NO**
Seizures or Convulsions	**YES**	**NO**

EARS:

Hard of Hearing or Deafness	**YES**	**NO**
Ringing or Noises in Your Ears	**YES**	**NO**
Frequent or Severe Ear Infections	**YES**	**NO**
Painful or swollen Ear Lobes	**YES**	**NO**

NOSE AND THROAT:

Sores in Your Nose or Mouth	**YES**	**NO**
Severe or Recurrent Nosebleeds	**YES**	**NO**
Frequent Sneezing	**YES**	**NO**
Sinus Trouble	**YES**	**NO**
Persistent Hoarseness	**YES**	**NO**
Tooth or Gum Infections	**YES**	**NO**

SKIN:

Rashes	**YES**	**NO**
Skin Sores	**YES**	**NO**
Sunburn Easily (Photosensitivity)	**YES**	**NO**
White Patches of Skin or Hair	**YES**	**NO**
Loss of Hair	**YES**	**NO**
Tick or Insect Bites	**YES**	**NO**
Painfully Cold Fingers	**YES**	**NO**
Severe Itching	**YES**	**NO**

Patient Name: ____

Have you had any of the following symptoms in the past year?

RESPIRATORY:

Severe or Frequent Colds	**YES**	**NO**
Constant Coughing	**YES**	**NO**
Coughing Up Blood	**YES**	**NO**
Recent Flu or Viral Infection	**YES**	**NO**
Wheezing or Asthma Attacks	**YES**	**NO**
Difficulty Breathing	**YES**	**NO**

CARDIOVASCULAR:

Chest Pain	**YES**	**NO**
Shortness of breath	**YES**	**NO**
Swelling of your legs	**YES**	**NO**

BLOOD:

Frequent or Easy Bruising	**YES**	**NO**
Frequent or Easy Bleeding	**YES**	**NO**
Have you Received Blood Transfusions	**YES**	**NO**

GASTROINTESTINAL:

Trouble Swallowing	**YES**	**NO**
Diarrhea	**YES**	**NO**
Bloody Stools	**YES**	**NO**
Stomach Ulcers	**YES**	**NO**
Jaundice or Yellow Skin	**YES**	**NO**

BONES AND JOINTS:

Stiff Joints	**YES**	**NO**
Painful or Swollen Joints	**YES**	**NO**
Stiff Lower Back	**YES**	**NO**
Back Pain while Sleeping or Awakening	**YES**	**NO**
Muscle Aches	**YES**	**NO**

Patient Name: ____________________________________

Have you had any of the following symptoms in the past year?

GENITOURINARY:

Kidney Problems	**YES**	**NO**
Bladder Trouble	**YES**	**NO**
Blood in your Urine	**YES**	**NO**
Urinary Discharge	**YES**	**NO**
Genital Sores or Ulcers	**YES**	**NO**
Prostatitis	**YES**	**NO**
Testicular Pain	**YES**	**NO**

OTHER:

Are you Pregnant?	**YES**	**NO**
Do you Plan to be Pregnant in the Future?	**YES**	**NO**

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Medical Insurance: Explanation and Information

There are many questions and misunderstandings regarding medical insurance coverage and terminologies used, in an ever-changing industry. There was a time when you paid your premiums through your employer group, had a very minimum co-payment of $5 or $10, and the insurance company would pay everything else. Unfortunately, that is not the case any longer. Below you will find information that we hope will assist you in understanding your insurance coverage:

Our office will bill your insurance company for all of the services provided to you (office visits, surgeries, procedures, etc.). Reimbursement from your insurance to our office is based on our contractual agreement and our participation status. Your benefit plan will determine your responsibilities for several types of payments. Included:

- **Copayment**: A fixed amount that your insurance company may require you to pay to the physician at the time of service. A copayment may be due for each visit, depending on the type of service you require.

- **Deductible**: The amount you are responsible to pay for Medical services rendered, before coverage begins, each plan year. Some insurance carriers have individual deductibles, and/or family deductibles, which are required before they will make payment for eligible benefits.

- **Coinsurance**: After your deductible has been satisfied, your insurance company will pay a percentage of the eligible amount of charges for services. You could be responsible for the remaining percentage of expenses beyond the deductible (up to a maximum). The percentage is determined by your benefit plan structure with your insurance company.

The terms under which insurance policies establish these limitations on reimbursement vary widely among policies and depend on your individual contract and benefit plan.

As the patient, it is your responsibility to know your insurance policy and benefits. We strongly encourage you to contact your insurance company to verify your plan benefits (copayments, deductible, and/or coinsurance). Co-payments, deductibles, coinsurance and non-covered services are the member's responsibility, and will be collected up front.

IT IS OUR OFFICE POLICY TO COLLECT YOUR COPAYMENT AT THE TIME OF SERVICE, WHEN YOU CHECK IN FOR YOUR APPOINTMENT. WE WILL ALSO COLLECT A FULL OR PARTIAL PAYMENT FOR YOUR OFFICE VISIT, PROCEDURE(S) AND/OR SURGERY, IF YOUR DEDUCTIBLE AND/OR COINSURANCE HAS NOT BEEN MET (unless other payment arrangements have been approved by our office).

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Driving Directions

From North (I-95 S/128 S):

Option 1:
Head South on I-95 S. Take exit 26 (US-20) toward Weston/Waltham. Take a slight left to merge onto US-20 East towards Waltham. Then keep right to stay on US-20E. Pass through one traffic light and follow signs for Rt 117 (Main St. is Rt 117). At second traffic light, turn left onto Stow St. Then turn left onto Main St. (Rt 117). You will be crossing over I-95/128. 1440 Main St. will be .25 mile up on your left.

Option 2: Via Bear Hill Road.
Head South on I-95 S. Take exit 27B to merge onto Winter St. Take a slight left to stay on Winter St. Take a slight right onto 2nd Ave. Keep left at fork to continue onto Bear Hill Rd. At the end of the road turn right onto Main St. (Rt 117). 1440 Main St. will be .25 mile up on your left.

From South (I-95 N/128 N):

Head North on I-95 N. Take exit 26 (US-20) toward Weston/Waltham. Keep right to merge onto US-20 East towards Waltham. Pass through one traffic light and follow signs for Rt 117 (Main St. is Rt 117). At second traffic light, turn left onto Stow St. Then turn left onto Main St. (Rt 117). You will be crossing over I-95/128. 1440 Main St. will be .25 mile up on your left.

From West (I-90):

Head East on I-90 E. Take exit 14 towards I-95/128. Keep left at fork and follow signs to merge onto I-95 N/128 N. Follow I-95 N and see directions above "From South".

From East (Rt 2):

Head North West on Rt 2 W. Take exit 52A to merge onto I-95 S toward Attleboro. Follow I-95 S and see directions above "From North".

From Logan International Airport (17.6 mi):

Exit Airport and follow signs for I-90 W. Keep left to merge onto I-90 W. Take exit 15 for I-95/128. Keep left at fork and follow signs to merge onto I-95 N/128 N. Follow I-95 N and see directions above "From South".

MBTA Directions

Red Line

Option 1: Via Red Line and Bus
Take the Red Line T to Central Square. Exit near the intersection of Prospect St and Massachusetts Ave. Walk North West on Massachusetts Ave towards Prospect St. Turn left onto Central Sq (Magazine St.) Then turn left onto Green St. (.07 mi walking/1 min). Take the 70 Bus from Green St. at Magazine St. Station towards Cederwood via Watertown & Waltham. Get off at Main St. at Stow St. Walk West on Main St. (Rt 117) toward Tower Rd for .25 mile (5 min). 1440 Main St. will be on your left.

Option 2: Via Commuter Rail
Take the Red Line T to Porter Square. Take the Fitchburg/South Acton Commuter Rail Line towards Fitchburg/Littleton/Rt 495. Get off at Waltham stop. Take the 70 Bus from the Carter St. Commuter Rail Station towards Cederwood via Watertown. Get off at Main St. at Stow St. Walk West on Main St. (Rt 117) toward Tower Rd for .25 mile (5 min). 1440 Main St. will be on your left.

Option 3: Note – sidewalk is not paved for entire walking route. Please use caution.
Take the Red Line T to Porter Square. Take the Fitchburg/South Acton Commuter Rail Line towards Fitchburg/Littleton/Rt 495. Get off at Kendal Green stop. Walk North East on Church St. towards North Ave (Rt 117). Turn right onto North Ave. North Ave turns into Main St. 1440 Main St. will be on your right (.6 mi walking/13 min).

Green Line / Orange Line

Option 1: Via Commuter Rail
Take the Green or Orange Line T to North Station. Take the Fitchburg/South Acton Commuter Rail Line towards Fitchburg/Littleton/Rt 495. Get off at Waltham stop. Take the 70 Bus from the Carter St. Commuter Rail Station towards Cederwood via Watertown. Get off at Main St. at

Stow St. Walk West on Main St. (Rt 117) toward Tower Rd for .25 mile (5 min). 1440 Main St. will be on your left.

Option 2: Note – sidewalk is not paved for entire walking route. Please use caution. Take the Green or Orange Line T to North Station. Take the Fitchburg/South Acton Commuter Rail Line towards Fitchburg/Littleton/Rt 495. Get off at Kendal Green stop. Walk North East on Church St. towards North Ave (Rt 117). Turn right onto North Ave. North Ave turns into Main St. 1440 Main St. will be on your right (.6 mi walking/13 min).

Silver Line (Airport Transit)

Take the Silver Line to South Station. Take the Red Line towards Alewife and follow any of the options listed above for "Red Line" transit.

Parking

There are multiple parking areas surrounding the building, as well as a large parking garage, all of which are free. Handicap access is available from Lot 1 as well as the top level of the parking garage Lot 2.

Hotels for MERSI

1440 Main Street, Suite 201
Waltham, MA 02451
Tel: 781-891-6377

Hyatt House Boston/Waltham
1.3 Miles from MERSI
54 Fourth Avenue
Waltham, Massachusetts, 02451 USA
Tel: 1-781-290-0026
http://waltham.house.hyatt.com/en/hotel/home.html

Embassy Suites Boston/Waltham
1.41 Miles from MERSI
550 Winter Street
Waltham, Massachusetts, 02451 USA
Tel: 1-781-890-6767
http://embassysuites3.hilton.com/en/hotels/massachusetts/embassy-suites-boston-waltham-BOSWSES/index.html

The Westin Waltham Boston
1.45 Miles from MERSI
70 Third Avenue
Waltham, Massachusetts, 02451 USA
Tel: 1-781-290-5600
http://www.westinwalthamboston.com/

Courtyard by Marriott Waltham
1.56 Miles from MERSI
387 Winter Street
Waltham, MA 02451 USA
Tel: 1-781-419-0900
http://www.marriott.com/hotels/travel/boswm-courtyard-boston-waltham/