C. STEPHEN FOSTER, M.D., F.A.C.S., F.A.C.R.
*Part-time Professor of Opthalmology*
*Harvard Medical School*

*Ocular Immunology and Uveitis Foundation*
*Founder and President*

*Associate Partners:*
STEPHEN ANESI, M.D.
PETER CHANG, M.D.

1440 Main Street, Suite 201
Waltham, Massachusetts 02451

**Massachusetts Eye Research and Surgery Institution**

Est. 2005

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 • pchang@mersi.com

Dear New Patient,

We are pleased to welcome you to the Massachusetts Eye Research and Surgery Institution (MERSI). Included in this new patients packet is billing policy information for you to read and sign 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, 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 new patient 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.

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# Fees for self-patients or inactive insurance

***It is our office policy to collect all payment in full at the day of your appointment.***

**If you do not have health insurance or your health insurance is inactive**, the fee for the consultation with Dr. Foster, Dr. Anesi or Dr. Chang is $700. We also require an additional $300 for a deposit for possible diagnostic testing. Initial: ______________

If no testing is needed, the $300 deposit will be reimbursed at the end of the visit. Initial: ___________

If testing is needed, you will be brought to the Front Desk and informed of the costs of each test. The costs of some tests may exceed the $300 deposit you paid at the beginning of your visit. Some of the costs may be less than the $300 deposit you paid. Initial: _______

You have the following options:

1) You have the option of being reimbursed the $300 deposit and re-scheduling the tests. Initial: ________

2) If the testing costs exceeds the $300 deposit, you will pay any additional costs that exceed the $300 deposit and have the testing done here on the same day as your appointment. Initial: ________

3) If the testing costs are less than the $300 deposit, you will be reimbursed any remaining difference from the $300 deposit and have the testing done the same day. Initial: _________

I have read the payment policy and agree to pay in-full all charges incurred for today's visit.

Print Name: ____________________________________________ Date: __________________________

Signature: ____________________________________________ Date: ___________________________

Print Name of Legal Guardian if Applicable: ___________________________________________________

Signature of Legal Guardian if Applicable: ___________________________________ Date: ___________

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## Medical Insurance: Explanation and Information

**Patient Name:**______________________________ **Date of Birth:**______________

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. 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.

**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. I agree to pay my copayment at each visit as determined by my insurance plan. Initial here: ________

**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. I agree to pay my deductible to MERSI as determined by my insurance policy. Initial here: _______

**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. I agree to pay my coinsurance at each office visit as determined by my insurance policy. Initial here: _______

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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).

I have read and agree to the terms above and understand I will be responsible for all payments associated with my insurance policy.

Patient Name: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Print Name of Legal Guardian if Applicable:

______________________________

Signature of Legal Guardian if Applicable: ______________________ Date: __________

MERSI

Massachusetts Eye Research and Surgery Institution

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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 ___ Specialist ____Mt. Auburn ___ MGH ____
Insurance Company ___ Radio ___ Newspaper _____ Angie's List ___
Facebook ___ Twitter ___ Internet ____ 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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## 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

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## 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 |
| --- | --- | --- |
| | | |
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**PAST Medical/Surgical HISTORY:**

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

| Eye Medical Condition and Eye Surgeries | Date |
| --- | --- |
| | |
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**Patient Name:** ______________________________

Please list all other **Medical History:**

| Medical Health Problems | Date |
| --- | --- |
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| NonEye Surgeries | Date |
| --- | --- |
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**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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# Driving Directions

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

**Option 1:**
Head South on I-95 S. Take exit 41 (old 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 43B (old 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 41 (old 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 123 (old 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 127A (old exit 52A) to merge onto I-95 S toward Attleboro. Follow I-95 S and see directions above "From North".

**From Logan International Airport:**

Exit Airport and follow signs for I-90 W. Keep left to merge onto I-90 W. Take exit 123A (old 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 Red Line and Uber
Take the Red Line to Alewife Station. From Alewife use Uber to get a ride to MERSI for (avg) $18. There is also a taxi stand at Alewife station as well. Follow the signs to the Auto pickup and drop off area. The fare back to Cambridge is avg of $26.00 with Uber. Travelers need to remember the Red Line is outbound towards Boston and marked Braintree which is the opposite end of the line. Additionally once you arrive at South Station you need to go all the way up and to the other side of the platforms to get to the SL bus marked for Logan.

**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.

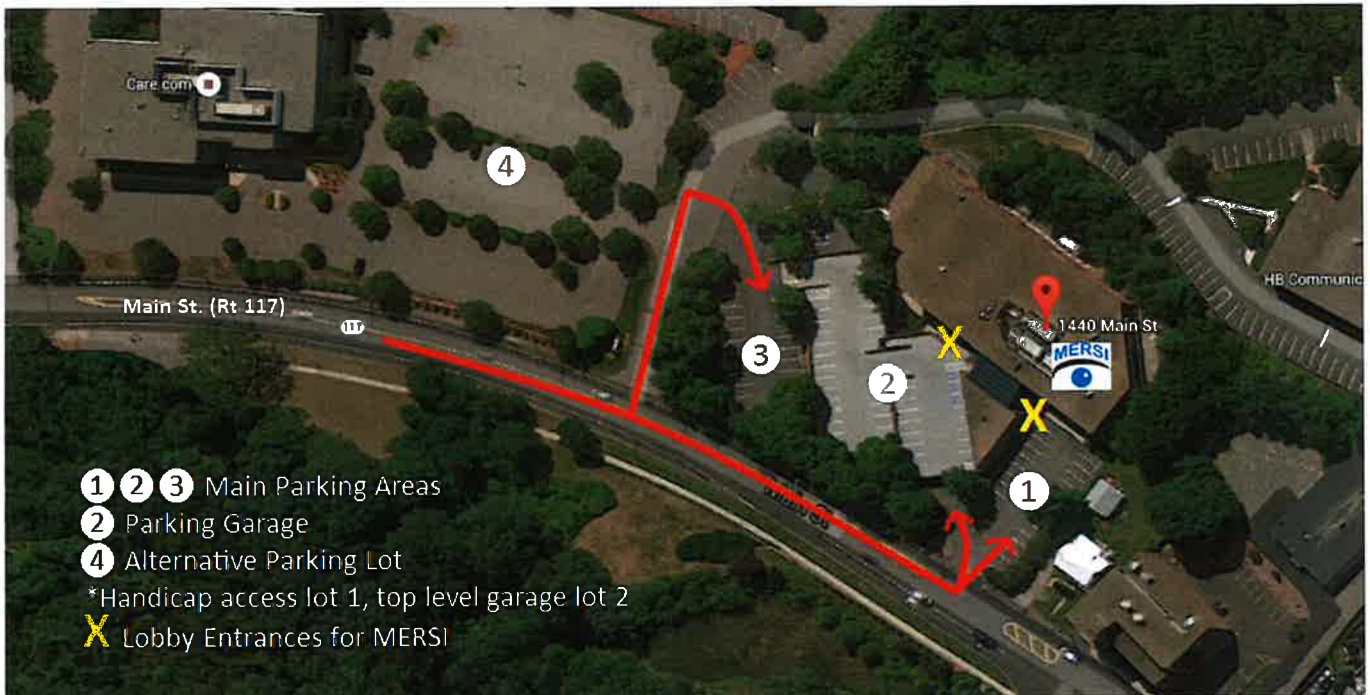
**Option 2**: Note – sidewalk is not paved for entire walking route. Please use caution.
Take the Green or Orange Line T to North Station. Take the Fitchburg/South Acton Commuter Rail Line towards Fitchburg/Littleton/Rt 495. Get off at Kendal Green stop. Walk North East on Church St. towards North Ave (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.



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Est. 2005

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**Residence Inn Boston Waltham**
250 2nd Ave
Waltham, MA 02451
Tel: 781-202-5140
https://www.marriott.com/en-us/hotels/boswa-residence-inn-boston-waltham/overview/

**Fairfield Inn & Suites Boston Waltham**
250 2nd Ave
Waltham, MA 02451
Tel: 781-202-5150
https://www.marriott.com/en-us/hotels/boswl-fairfield-inn-and-suites-boston-waltham/overview/

**The Westin Waltham Boston**
70 3rd Ave
Waltham, MA 02451
Tel: 781-290-5600
https://www.marriott.com/en-us/hotels/bosww-the-westin-waltham-boston/overview/?scid=f2ae0541-1279-4f24-b197-a979c79310b0

**Courtyard by Marriott Waltham**
387 Winter Street
Waltham, MA 02451
Tel: 781-419-0900
https://www.marriott.com/en-us/hotels/boswm-courtyard-boston-waltham/overview/?scid=f2ae0541-1279-4f24-b197-a979c79310b0