NEWTON-WELLESLEY
AMBULATORY CARE CENTER
NEWTON

Helpful Telephone Numbers

Pre-Registration	855-890-9241
Hospital Billing (NWH)	617-726-3884
Physician/Provider Billing (MGPO)	617-726-3884
Web Address	**nwh.org**

Pre-Registration
Please call up to 7 days prior to your appointment to pre-register for this appointment. This call typically takes a few minutes. Please have your insurance information available. Insurance plans vary in their requirements. Your plan may require a potential referral, authorization, or out-of-pocket payment for this visit. Pre-registration is available Monday-Friday from 8 AM – 5 PM at 855-890-9241, or you can pre-register at our website: **https://www.nwh.org/home/pre-registration/**

Parking
There is plenty of free parking all around the building. You can enter through the front or back entrance. There is also handicapped parking in the back of the building.

****PLEASE NOTE OUR NEW ADDRESS****
The Spine Center
159 Wells Ave, Newton, MA 02459
Ph: 617-243-5777 Fax: 617-243-6110

Patient Instructions
Our patient hours are Monday through Friday 8:00 AM to 5:30 PM. Our phone hours are Monday through Friday 8:00 AM to 4:30 PM. We ask that you arrive 30 minutes prior to your appointment time in order to prepare you for your visit. Please print the Spine Center New Patient Packet (attached or located on our website at **http://www.nwh.org/clinical-centers/spine-center/your-visit/.**

For your comfort during the exam, you may want to bring shorts and a t-shirt or sports bra. ***We require that patients refrain from using creams, scented lotions or perfumes on the day of their visit.***

MRI's or X-rays
If you have had any recent MRIs done in the year prior to your visit and they were not performed at NWH or MGH, please bring the images and reports to your appointment.

Insurance Referrals
If your insurance requires a referral to see a specialist, you are responsible for obtaining that referral from your Primary Care Physician prior to your appointment and ensuring that we have received it. If the department has not received the referral, your appointment will be cancelled or you will be asked to sign a waiver stating that you are aware that you are being seen without a referral and no further appointments or diagnostic tests will be scheduled. Please fax all referrals to 857-282-5654.

Co-Payments
If your insurance requires a copayment, it is due at the time of your visit. We accept payment in the form of a credit card. Full payment for self-pay visits and procedures, such as prolotherapy and acupuncture are due at the time of the visit.

The Spine Center is a hospital based outpatient clinic. It is standard to receive one bill representing the physician charges from their billing provider (MGPO) and another bill representing the hospital/facility charges from NWH. For questions regarding the physician's bill, please call 617-726-3884. For questions regarding the hospital bill, please call 617-726-3884.

NEWTON-WELLESLEY AMBULATORY CARE CENTER
NEWTON

Spine Center/Newton-Wellesley Hospital
159 Wells Ave
Newton, MA 02459

Label
or

Name:

Date of Birth:

Spine Center Questionnaire

Are you ☐ Right ☐ Left Handed? **When** did your current problem start? ___/___/___ (month/day/year)

What is the main problem(s) for which you are seeking treatment at the Spine Center?

_____

Please list prior spine surgeries, if any (date and type): _____

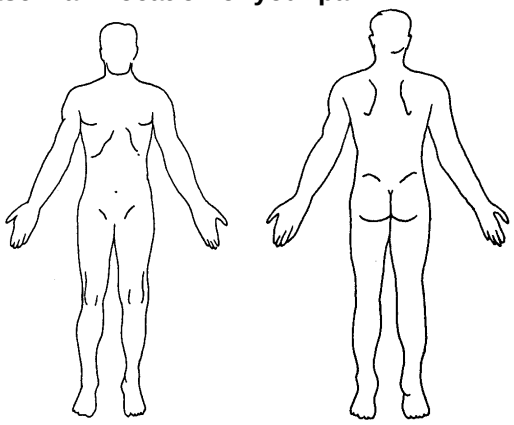
Please indicate how your present symptoms began?
☐ Auto accident ☐ While working ☐ Other _____

My symptoms have: ☐ remained the same ☐ become more severe ☐ become less severe

Which of the following best describes your pain ratio?
☐ 100% back or neck ☐ 100% leg or arm ☐ 75% back or neck and 25% leg or arm
☐ 50% back or neck and 50% leg or arm ☐ 25% back or neck and 75% leg or arm

Circle your **current** pain: **(no pain)** 0 1 2 3 4 5 6 7 8 9 10 **(severe, Emergency Room)**

Please mark location of your pain:



How would you describe your pain?
☐ burning ☐ sharp ☐ electric-like ☐ pins/needles
☐ shooting ☐ stabbing ☐ aching ☐ dull
☐ throbbing ☐ other _____

How often do you have your pain?
☐ Constant, every minute of the day
☐ Intermittent and occurring daily
☐ Intermittent and occurring on most days
☐ Infrequent

How do the following affect your pain (please check one for each item)?

	Increase	Decrease	No change
Walking	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Rising from sitting	☐	☐	☐
Bending forward	☐	☐	☐
Lying on your side	☐	☐	☐

Please check the approximate amount of time you can perform the following activities:

	unable	15 minutes	30 minutes	45 minutes	1 hour	indefinitely
Sit	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐

Please list below medications that you have tried for your **current pain**:

_____

Please check all treatments you have tried for your **current pain**:

Treatment	Dates	No Relief	Moderate Relief	Excellent Relief
☐ Physical Therapy	_____	☐	☐	☐
☐ Injections (epidural, facet, etc.) _____	_____	☐	☐	☐
☐ Chiropractic	_____	☐	☐	☐

Please list all diagnostic studies that you have had for this problem (indicate approximate dates):

MRI/CT:
X-Rays:
EMG:

CURRENT MEDICATIONS (please fill out the dosages and how often taken):

_____ _____ _____

_____ _____ _____

ALLERGIES: _____

Please check all items you feel are currently applicable to you:

☐ **leg weakness**	☐ **difficult or frequent urination**	☐ **genital numbness**	☐ **fever or chills**
☐ **severe nighttime pain**	☐ **recent infections**	☐ **feeling depressed**	☐ **weight loss**
☐ **arm weakness**	☐ arm or leg numbness	☐ decreased appetite	☐ anxiety
☐ fatigue	☐ poor sleep	☐ headaches	☐ double vision
☐ dizziness	☐ hoarse voice	☐ difficulty hearing	☐ swollen glands
☐ swollen joints	☐ rash	☐ chest pain	☐ shortness of breath
☐ **leg swelling**	☐ abdominal pain	☐ nausea	☐ stomach ulcer
☐ acid reflux	☐ **blood in stool**	☐ **black stool**	☐ bowel accidents
☐ **blood in urine**	☐ prostate enlargement	☐ erectile problems	☐ abnormal bruising
☐ thyroid problem	☐ muscle aches		

Have you experienced significant stress this past year? Please explain: _____

Have you had any of the following health problems (please check all that apply)?

☐ High blood pressure ☐ Diabetes ☐ **Kidney disease** ☐ Heart disease ☐ Osteoporosis
☐ **Liver disease** ☐ **Bleeding** ☐ **Cancer, please specify** _____

Do you have any pending health related litigation? ☐ Yes ☐ No _____
What is your occupation? _____
Are you currently working? ☐ Yes ☐ No If yes, then how many hours per week? _____
If you are currently unemployed, indicate how long you have been off work: _____

Are you ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced? Number of children? _____
Do you smoke? ☐ Nonsmoker ☐ Current smoker ☐ Quit (date: _____)
Do you drink alcohol? ☐ No ☐ Yes (drinks/week: _____)
What kind of exercise do you do? How many days per week and for how long per session?
_____
Is there a history of low back or neck pain, arthritis in your family? _____

Patient Signature:_____ **Date:**_____

NEWTON-WELLESLEY AMBULATORY CARE CENTER NEWTON

NEWTON-WELLESLEY HOSPITAL
NEWTON, MASSACHUSETTS
SPINE CENTER

EFFECTIVE DATE:
10/30/12

POLICY TYPE: **ADMIN** ___
CLINICAL ___
DEPARTMENTAL X

SPINE CENTER CANCELLATION, LATE, NO SHOW AND WAIT LIST POLICY

PURPOSE: The purpose of this policy is to ensure that all patients are scheduled appropriately should they cancel, fail to appear for their appointment or request placement on a wait list.

SCOPE: This policy applies to the Spine Center in the Department of Rehabilitation Services.

POLICY & PROCEDURE STATEMENT: All Spine Center staff and patients will be made aware of this policy. Staff will be expected to schedule visits accordingly. A record of cancellations and no shows is maintained within the patient's scheduling history.

DEFINITIONS: N/A

PROCESS:

I. CANCELLATION: A patient may call any time up to the day before the scheduled appointment to cancel an appointment. A Monday appointment must be cancelled no later than the Friday before. A patient may reschedule a cancelled appointment.

II. LATE: A patient who is more than 15 minutes late for an evaluation or 10 minutes late for a follow up appointment without prior notification of staff may need to be rescheduled. This decision will be up to the discretion of the individual physician and may require the patient to wait until scheduled patients are seen.

III. NO SHOW: A patient who attempts to cancel an appointment the day of the appointment except in extenuating circumstances is considered a NO SHOW. Three "NO SHOW'S" over the total of a year will prevent any further scheduling within the Spine Center. The patient will be referred to at least 2 other programs that will meet their needs.

IV. WAIT LIST: When patients request placement on a wait list, their name, the nature of their chief complaint, any extenuating circumstances, and their temporarily assigned appointment date will be logged. Every effort to accommodate an earlier appointment time attempted based upon acuity and time to next appointment.

REFERENCES: N/A

ORIGINATOR: SPINE CENTER, DEPARTMENT OF REHABILITATION SERVICES

ORIGINATION DATE: 07/01/02

SPONSOR: Spine Center Coordinator

COLLABORATOR(S): N/A

REVIEWED: July 2006 **REVISED:** July 2015

PLEASE SIGN OTHER SIDE

CROSS-REFERENCE: N/A

APPROVAL BY: Medical Co-Director, The Spine Center; Director of Ambulatory Services

CANCELLATION: N/A

KEY SEARCH WORDS: cancellation policy, appointments, late, no show, wait list, cancellation, spine, spine center

ATTACHMENTS: N/A

Acknowledgement of Receipt of Spine Center Cancellation, Late and No Show Policy:

The goal of the staff at the Spine Center is to accommodate patient requests for an appointment to see their provider in a timely manner. This can be a challenge when appointments are missed or canceled at the last minute. The staff keeps a list of patients waiting for an appointment. In order to effectively use this list, the clinic needs 24 hours to contact patients and offer them a more convenient appointment time.

In an effort to improve this process, the Spine Center has developed a policy for patients to use as a guide when it is necessary to cancel or change an appointment. We do understand that there are extenuating circumstances and we will handle these on a case by case basis. Please review the policy and acknowledge below that you have received a copy.

I have received and reviewed a copy of the Spine Center Policy.

Signature: _____ Date: _____