Emerson Hospital
Premium Care. Personal Touch.

Emerson Primary Care of Bedford
55 North Road, Suite 120, Bedford, MA 01730
Phone: 339-215-5100 Fax: 339-215-5180

Sunita Hanjura, MD
Katherine Lynch, MD
Daniel Perl, MD
Heidi Doreau, NP

NEW PATIENT PACKAGE

Welcome to our practice! We look forward to meeting you on _____

for your GET ESTABLISHED appointment with _____.

We would like to take this opportunity to welcome you to our Patient-Centered medical practice and to thank you for choosing our providers to participate in your healthcare. We look forward to delivering personalized, comprehensive health care focusing on your specialized needs, your wellness and health prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioner, medical assistants, and office staff work closely in a "team approach" to support your patient care. We provide organized, evidence-based care, to proactively remind you about any required tests and/or exams. Great health care is based on best practices, and is coordinated around standard protocols. We are accountable for your care, and use your feedback to improve care.

Our office is open Monday through Friday from 8am-5pm. Every effort is made to see our patients for medical problems during daytime hours, and we will do our best to accommodate you. We have same-day appointments reserved for both urgent and routine care. After-hours care will be provided by an on-call physician who can be reached by calling our office directly. Our on-call team is prepared to give advice and record your concerns to ensure proper care. Please understand that if you arrive 15 minutes late for your appointment, we may have to reschedule you to a more convenient time. In addition, if you have missed 2 or more appointments in a calendar year, we may not be able to schedule you for another appointment at Emerson Primary Care of Bedford.

As your primary care physician, we work collaboratively with Emerson Hospital and the Partners Network offering a wide range of physicians to coordinate all aspects of our patient care, including inpatient hospitalization, specialty consultation care, nursing facilities and community resources as needed.

Before your visit, please notify your health insurance company of your new primary care provider. Need health insurance? Apply for health and dental insurance through the Massachusetts Health Connector at www.mahealthconnector.org. Remember to bring your health insurance card and a photo ID to your appointment.

We request that your records from outside physicians and institutions be forwarded to us before your appointment. This will ensure a better continuity of care for you. If your former providers are affiliated with the Emerson network, we can obtain your records. If you require assistance obtaining your records, please let us know.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status, and these forms contain the necessary information to complete this process and properly evaluate your health condition. In addition, be sure to bring a complete list of all your allergies and medications, as well as the strength and dose of each medication.

If for any reason you are unable to keep your appointment, please give us 24 hour notice to cancel or reschedule your appointment. Once again, we would like to thank you for choosing us as your primary care provider and we look forward to helping you with your medical needs. Our team will provide you with the information and support you need to achieve your health care goals.

Respectfully,

The Providers and Staff of Emerson Primary Care of Bedford

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IF YOU ARE BETWEEN THE AGES OF 18-21, THIS INFORMATION PERTAINS TO YOU:

When you become a patient in our medical practice, you will be transitioning from Pediatric-Focused health care into Adult-Focused health care. We, at Emerson Primary Care of Bedford, want to make this transition as easy as possible for you.

What are some of the changes that I should expect?

With adult health care, you will be expected to make decisions and have more responsibility for your medical care. At our practice:

1) You will decide whether to accept or refuse medical treatment.
2) You may decide how much your parents are involved in your medical decisions.
3) You will be responsible for any medical costs not covered by health insurance. Discuss this with your parents.

How can I prepare for these changes?

Become more involved in our health care immediately. These are some suggestions

1) Take the lead on discussions with your health care team.
2) Ask questions. Some people find it helpful to write a list of questions before their health care visits.
3) If you don't have questions, pay attention to the type of questions your parent has asked.
4) Schedule your own appointments and track them on your calendar.
5) Practice going to the pharmacy to fill prescriptions with your parents.

What can you do to help as an adult member of your patient-centered medical home?

Be an active team player

1) Ask health questions so you understand your diagnosis and needs.
2) Communicate with your medical home team.
3) Tell us about your other health care providers, including visits to the emergency department or urgent care.

Take care of your health

1) Collaborate with the team to develop your health care plan.
2) Set reachable goals
3) Make sure you understand how to follow the plan.
4) Tell your team if you have trouble following the plan on taking your medications
5) Review the plan and change the goals as needed.

Have a checklist for your appointments.

1) Bring a list of your questions with you.
2) Ask the most important ones first.
3) Write down the answers.
4) Before you leave the office, be sure to schedule any follow-up appointments recommended by your provider.

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NEW PATIENT REGISTRATION

TODAY'S DATE: _____ How did you hear about us? _____

Patient Information
Last Name: _____ First Name: _____ M.I.:_____
Social Security #:_____ Date of Birth: _____ Gender: M □ F □
Marital Status: Single: □ Married: □ Divorced: □ Widowed: □ Race: _____ Ethnicity: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Employer: _____ Occupation: _____
E-Mail Address: _____ Pharmacy and Location: _____

Primary Insurance Information: (Required Information)
Policy Holder Name: _____ Policy Holder SS#:_____
Policy Holder Date of Birth: _____ Policy Holder Employer: _____
Policy Holder Insurance Company: _____

Secondary Insurance Information: (Required Information)
Policy Holder Name: _____ Policy Holder SS#:_____
Policy Holder Date of Birth: _____ Policy Holder Employer: _____
Policy Holder Insurance Company: _____

Spouse and/or Responsible Party Information: (Required Information)
Name: _____ Social Security #:_____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____
I give my permission to share medical information with above-named individual. Y □ N □

In Case of Emergency Please Contact: (Required Information)
Contact Name: _____ Contact Number: _____ Relationship: _____
Nearest Relative Other Than Spouse: _____ Phone Number: _____

Do You Have a HealthCare Proxy (HCP)? Y □ N □ Name and Contact # of HCP: _____

Who can we share your medical information with? Name and Contact # of HCP: _____

Do You Have an Advanced Medical Directive? Y □ N □

Social History:
Cigarettes/Cigars: _____ packs/day for _____years. Date Quit? _____
Alcoholic drinks: _____ drinks per day. Date Quit? _____
Drug Use: _____
Coffee: _____ cups/day Soda/tea: _____ glasses/day
Exercise type: _____ Days/week: _____
Hobbies: _____
Medical Questionnaire

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Past Medical History: (check any of the following which you have or been treated for)

□ High Blood Pressure □ Cardiac Disease □ Diabetes □ Cancer
□ Liver Disease □ Kidney Disease □ Asthma/Emphysema □ Stomach Trouble
□ Arthritis (Joint Problems) □ Neurological Disorder (Stroke, etc.) □ Other _____

Surgical Procedures	**Year and Where**	**Hospitalizations**	**Year and Where**

Regular Medications: (including dosage/frequency; include prescription, over-the-counter, vitamins, birth control, etc.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications: _____ _____
_____ _____
_____ _____

Other Allergies: _____ _____
_____ _____
_____ _____

Family History: (check all that apply)	**Relation**	**Age it Occurred**
□ Hypertension		
□ Heart Attack		
□ Strokes		
□ Diabetes		
□ Ovarian Cancer		
□ Breast Cancer		
□ Colon Cancer		
□ Other Cancer		
□ Tuberculosis		
□ Glaucoma		
□ Neurological Disorder		
□ Other: _____		
□ Other: _____		

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Review of Systems: (check if you have or have had any of the following

General
□ Recent Weight Loss or Gain
□ Fevers or Nights Sweats
□ Mood Disturbance (i.e. Depression, Anxiety, etc.)
□ Fatigue

Head/Neurologic
□ Headache
□ Dizziness
□ Fainting
□ Paralysis or Weakness of Limbs
□ Numbness
□ Tremor or Shakes
□ Poor Coordination
□ Difficulty in Speech

Ear, Nose & Throat
□ Seeing Double
□ Flashing Lights Before Your Eyes
□ Recent Change in Eyesight
□ Cataracts
□ Hearing Loss
□ Ringing in the Ears
□ Nose Bleed
□ Difficulty Swallowing
□ Hoarseness or Voice Change

Genitourinary
□ Increased Frequency or Urgency of Urination
□ Prostate Problems
□ Incontinence

Preventive Care:
Last Tetanus Shot: _____
Last Flu Shot: _____
DEXA (Bone Scan): _____
Last Mammogram Date: _____
Last PAP Date: _____
Last Colonoscopy Date: _____

Skin/Hair
□ Rashes
□ Sores
□ Hair Loss
□ Itching

Stomach and Bowels
□ Nausea/Vomiting
□ Indigestion, Belching, or Excess Gas
□ Abdominal Pain
□ Diarrhea or Constipation
□ Bloody or Black Stools

Muscles, Bones, and Joints
□ Joint Pain or Stiffness
□ Joint Swelling or Redness
□ Backache
□ Muscle Aches

Heart and Lungs
□ Heart Attack
□ Angina or Chest Pain
□ Asthma or Wheezing
□ Cough
□ Irregular or Rapid Heart Beat
□ Swelling (Edema)
□ Murmurs

Neck
□ Pain or Stiffness in the Neck

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Please check off box if disease is present or the age it occurred/diagnosed	Father	Pat Grandfather	Pat Grandmother	Mother	Mat Grandfather	Mat Grandmother	Brother	Sister	Uncle	Aunt	Other
Cancer											
Colon											
Lung											
Breast											
Ovarian											
Prostate											
Skin											
Other Cancer:											
Heart disease											
Heart attack											
High blood pressure											
Stroke											
High cholesterol											
Diabetes											
Kidney disease											
Asthma											
COPD/Emphysema											
Depression											
Substance abuse											
Thyroid disease											

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PRINT NAME: _____ DATE OF BIRTH: _____

EMERSON PRIMARY CARE

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO TREAT/ DISCLOSE HEALTH INFORMATION

ACKNOWLEDGMENT OF RECEIPT OF EMERSON'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, the Emerson Hospital Health Centers in Westford and Groton, Emerson Hospital Radiology at Concord Hillside, Emerson Practice Associates, Emerson Primary Care or any health care professional providing services in the Hospital's clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson").

CONSENT FOR TREATMENT/TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultants as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson may treat me, seek payment from third parties for such treatment, and generally carry on Emerson's health care operations (e.g., quality assurance). I also authorize Emerson to disclose my medical/insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY:
In consideration of services rendered, I hereby irrevocably assign and transfer to Emerson Hospital, its physicians, assistants and consultants rights, title and interests in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to sue or make claim for benefits, individually, should coverage be denied by an insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital and its physicians, assistants, and consultants all benefits due under said policy(ies) by reason of services rendered therein. I will pay Emerson Hospital, its physicians, assistants, and consultants for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies) that my providers are permitted to collect. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____
Signature of Personal Representative Date

Description of Authority: _____

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Your rights regarding your personal health information:

This describes how your personal health information may be used and disclosed and how you can get access to this information. Please read it carefully. You have the following rights regarding your medical record:

Right to Inspect and Copy. You may request access to your medical information and your billing records. To inspect and copy billing records or medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Record Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that your medical information is incorrect or incomplete, you may submit a written request for an amendment to the Medical Record Department.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain types of disclosures we made of your medical information. To request this list of disclosures, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Requests made more than once during a 12-month period will incur a copying charge.

Right to Request Restrictions. You may request restrictions on our use and disclosure of your medical information. While we will consider all requests for additional restrictions carefully, we are not required to agree to all requested restrictions. If you wish to request additional restrictions, please submit a written request to the Privacy Officer.

Right to Receive Confidential Communications.
You may request, and we will accommodate, any reasonable written request to receive your medical information by alternative means of communication or at alternative locations; for example, information as to how payment, if any, will be handled and alternate address and/or contact information.

Right to Revoke Your Authorization. You may revoke any written authorization you have signed with a written request. We are unable to take back any disclosures that were made before you revoked your authorization.

Right to be notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured Protected Health Information (PHI). Notice of any such breach will be made in accordance with federal requirements.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Privacy Notice. You may also print and copy the Notice from our website at www.emersonhospital.org. Emerson Hospital maintains medical records for at least 20 years after the patient's discharge or after the final treatment, as required by state law; a copy of the hospital's medical record retention policy is available upon request.

Changes to this Privacy Notice:

The hospital may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all medical information that we maintain, including any information created or received prior to issuing the new Notice. Changes to this Notice will be posted at Emerson Hospital, the Emerson Hospital Health Centers in Westford, Groton, Sudbury; Emerson Hospital Radiology at Concord Hillside, all other Emerson Centers and on our web site at www.emersonhospital.org. You also may obtain any new Notice by contacting Emerson Hospital.

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Questions and complaints:

If you would like more information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your medical information, you may contact our Privacy Officer at privacyofficer@emersonhosp.org or 978-287-3995.

You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. JFK Federal Building – Room 1875, Boston, MA 02203. Voice phone 617.565.1340, or e-mail OCRComplaint@hhs.gov. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Quality and Patient Safety Department	978-287-3095	
Privacy Officer	978-287-3995	privacyofficer@emersonhosp.org
Medical Record Department	978-287-3720	978-287-3652 fax
Billing Department	978-287-3020	

Please send your privacy request in writing to: Emerson Health Systems, Inc. and its related entities, are acting as an organized health care arrangement (OHCA). The following entities are included in the OHCA: Emerson Hospital, Emerson Hospital Health Centers in Westford, Groton, Sudbury, and all other Emerson Centers, Emerson Center for Specialty Care, Emerson Center for Sports Rehabilitation and Specialty Services, Emerson Practice Associates, Emerson Hospital Radiology at Concord Hillside, and the following:

• Any health care professional providing services to you in the Hospital's clinically integrated care setting, regardless of whether specific services are provided by the Hospital's employees or by independent members of Emerson Hospital's Medical Staff.

• All department units of Emerson Hospital and the Westford, Sudbury and Groton Health Centers.

• Any member of a volunteer group we allow to help you while you are in Emerson Hospital.

• All employees, staff and other Emerson Hospital personnel.

This Privacy Notice is effective as of April 14, 2003. Reviewed and revised, January 2011.

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Authorization for the Discussion of Protected Health Information

Patient Name: _____ Date of Birth: _____

Authorization:

1. I, _____, hereby authorize
   (Name of Patient or Patient's Legally Authorized Representative)

2. Name of person or organization: _____
   Street Address: _____
   City, State, Zip: _____ Telephone: _____

3. To release and/or discuss the following information
   Complete Record Outpatient Care Inpatient Care
   X-Ray Results Laboratory Results Treatment Plan Update

Other: _____

If my record contains the following information, it is also released if *CHECKED* in boxes below:

£ Substance Abuse £ Mental Health Treatment £ HIV Testing or Treatment

Signature:

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires one year from today's date, or upon the following specified event:
_____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Patient Signature: _____ Relationship: _____

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PRINT patient name _____ Date of Birth _____

PRINT email address _____

PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between healthcare providers that is intended to improve the quality and safety of patient care. I have received and had an opportunity to review the "Mass HIway: Fact Sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (the "Practice"). I hereby give the Practice permission to use MassHIway to:

1. Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault, substance abuse records, reproductive health concerns and genetic testing results.

2. Send to the Mass HIway my name, date of birth, gender, email, home address, phone number, and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.

3. I understand that I may withdraw my permission for the Practice to share information ("Opt-out") at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

Signature of Patient or Patient's Legal Representative _____ Date of Signature _____

Print Name of Patient's Legal Representative (if applicable) _____ Relationship to Patient _____

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The Mass HIway Fact Sheet for Patients

Introduction:
The Mass HIway is a secure statewide computer network that allows your healthcare providers to safely and quickly send your health information to where it is most needed. A doctor or nurse can care for you better when he or she has important information about your health history. The Mass HIway is designed to make this safer and faster. The goal is better care coordination and quality for you and your family.

What is the Mass HIway?
• Mass HIway is a secure statewide computer network that can help healthcare providers coordinate your care. It is a new tool that can be used to:
>> Locate other members of your healthcare team
>> Securely request, send, and receive your health information
• It's voluntary. State Law requires all healthcare organizations get patient consent (by signing a consent form) before they may use the Mass HIway for that patient's care.
• The Mass HIway is managed by the Commonwealth of Massachusetts' Executive Office of Health and Human Services (EOHHS).

How does the Mass HIway help me?*
• If you are in an accident or have a sudden illness and go to the emergency room, the hospital might not know your medical history. The emergency room doctor can use the Mass HIway to find out if you are allergic to any medicines or if you have other health problems.
• If you were discharged from the hospital and are going for a follow-up appointment, the hospital can use Mass HIway to send your doctor a note about your hospital stay. Then, you and your doctor could spend time talking about your follow-up care instead of paperwork.
• If you get tests done, the doctor can use the Mass HIway to send the results to other members of your healthcare team, like your specialist. This helps them coordinate your care. It can also save you time and money by reducing the need for repeat tests.
• If you have a chronic condition your health insurer case manager can use the Mass HIway to communicate with your doctors to coordinate your care and help you stay healthy.
• If you see a new doctor, he or she can use the Mass HIway to locate other organizations where you have received care. Your new doctor can request your health information so they can treat you better.
* Remember, the Mass HIway is a new tool, so all of your providers may not be using it yet. There will be more benefits for you as more healthcare organizations use the Mass HIway.

Who can use the Mass HIway and why?
• Mass HIway may only be used by healthcare organizations (like doctors' offices, clinics, hospitals, public health agencies, and health insurers).
• Mass HIway may only be used for information sharing as allowed by law (to plan treatment, to get payment from insurance companies, and operations, like reporting care quality). Speak to your doctor or office staff about what information is sent and why.

Does the Mass HIway store my health information?
• No. The patient's medical record itself is not part of the Mass HIway system. The Mass HIway cannot see any health information sent over the network. The medical record is stored by the healthcare organization, the same way it is today.

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What happens when I give my consent?
• With your consent, you allow the healthcare organization to send the following information about you to the Mass HIway to be stored in a secure database. This data is used to search for other healthcare organizations that have health information about you for request.
>> Full name
>> Date of birth
>> Home address
>> E-mail
>> Phone number
>> Gender
>> Medical record number

• With your consent, you allow your relationship to that organization to be listed in the Mass HIway network. A relationship means that you have received care at that organization and have given consent to that organization to use the Mass HIway. Your relationship can only be seen by other organizations where you have given consent.
• With your consent, you allow healthcare providers or other health workers at that organization to use Mass HIway to request, send, and receive health information about you for your care. Examples of other health workers could be a lab technician or someone in the medical records office. Speak with your doctor or the office staff about who is using the Mass HIway at that organization.

What if I say 'No' or don't sign the consent form? What if I change my mind?
• That's ok. But, if you do not consent for the Mass HIway, your providers will continue to send your health information using other ways, like fax or the mail. But that takes time and it's hard to control who reads a fax or opens a piece of mail, so your information may not always be protected. The Mass HIway is designed to make this safer and faster.
• Each healthcare organization will have its own process for you to change your choice, so speak with your doctor or the office staff to learn how.

How does the Mass HIway protect my information?*
The Mass HIway has security measures in place to protect your information that aren't true of current methods, like fax, mail, or portable media like a CD or USB (flash drive), such as:
• Using a special code so that only authorized providers can read the information sent over the Mass HIway (this is known as encrypting data).
• Encrypting the Mass HIway database of demographic information, and keeping it behind a firewall (this prevents access by the wrong people).
• Having a way to oversee who has access to the system and who has used it for a particular patient's healthcare. You can get a copy of this list by speaking with your provider or the office staff and asking for an "accounting of disclosures".
• A user must have valid usernames and strong passwords.
• All healthcare organizations using the Mass HIway have signed a contract to make sure they follow all state and federal laws to protect your information.
• You will still need to give special permission for providers to request and receive certain sensitive information. This includes HIV and genetic testing results and substance abuse.
* There is always a risk with technology, but the Mass HIway uses the highest security standards to protect your information. Most of the data breaches you hear about are from insecure laptops being lost, or information being sent without encryption (coding), like a CD or a USB (flash drive). The Mass HIway can help replace these methods.

How do I get more information?
• Talk with your doctor or their office staff about how they are using the Mass HIway.
• Visit www.masshiway.net, email us at Masshiway@state.ma.us, or call 1-855-MAHIway (1-855-624-4929) Option 3.

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EMERSON PATIENT PORTAL

EmersonConnect.Emersonhosp.org

Emerson Connect allows patients to access their health information free 24-hours a day.

By joining the Patient Portal, you can:

View: Past and future appointments
Lab results
Past and current medications
Immunization records and vital signs
Other available medical record information

Request: Medication refills
Electronic copies of specific documents in your chart
Referrals to another provider or specialist

Access: Forms and resource links offered by our office

Update: Personal / demographic information and emergency contact(s)

Send: A secure message to your healthcare provider

If you are interested in joining the Patient Portal, please provide us with your email address. We will register your email and you will receive instructions on how to register for the Patient Portal.

Email Address: _____

Name: _____ Date: _____

*Due to Massachusetts law pertaining to mature minors, a portal account will not be available for patients between the ages of 13 and 18.

ALWAYS CONTACT THE YOUR PHYSICIAN'S OFFICE BY PHONE FOR ANY URGENT MEDICAL CONDITION.

Emerson Hospital
Premium Care. Personal Touch.

Emerson Primary Care of Bedford
55 North Road, Suite 120, Bedford, MA 01730
Phone: 339-215-5100 Fax: 339-215-5180

Sunita Hanjura, MD
Katherine Lynch, MD
Daniel Perl, MD
Heidi Doreau, NP

EMERSON HOSPITAL CONNECT - PATIENT PORTAL

Patients who receive care at Emerson Hospital or one of our satellite centers can view their personal health information using Emerson Hospital Connect.

Emerson Hospital's patient portal, Emerson Hospital Connect, is a secure website. Patients who receive care at Emerson Hospital or one of our satellite centers can view their personal health information 24 hours a day using Emerson Hospital Connect. This portal allows patients to access their information after logging in with a username and password.

The information included is for services the hospital provides, not private physician practices (PCP or specialists). There is no cost associated with signing up.

Due to Massachusetts regulations regarding mature minors, a portal account will not be available for patients between the ages of 13 to 18.

What services and information will Emerson Hospital Connect provide?

- Information pertaining to each of your visits at Emerson Hospital or our satellite centers
- Insurance information
- Detailed visit reports including most Laboratory and Radiology results, documented history & physical, and discharge summary
- Vital signs documented during your inpatient visit
- List of medications ordered or discontinued upon discharge
- Past and future appointments scheduled at Emerson or our satellite centers
- Set-up custom email reminders for upcoming appointments
- Diagnoses associated to your visits
- Ability to print, download or email your personal health information for individual use or to provide to outside physicians

Emerson Hospital Connect Patient Portal is completely secure, so you can be confident that your private information is protected. Only you or an authorized family member can access your personal Emerson Hospital Connect Patient Portal.

Steps to Sign Up

1. Obtain a 6-digit code and step-by-step instructions via one of these two methods:
   - If you are still an in-patient at Emerson, contact your nurse or dial x3044 to request a representative to assist in the registration process.
   - Call the Medical Records Department at 978-287-7338 and ask to sign-up for Emerson Hospital Connect.
2. Visit www.emersonhospitalconnect.org and click on the sign in button towards the middle of the screen.
3. The computer will prompt you for your unique 6-digit code and ask you to create a username and password.
4. Follow the step-by-step process. You will need the following information to complete the registration:
   - ✔ E-mail address
   - ✔ Two Security Questions
   - ✔ First and Last Name
   - ✔ Date of Birth

Questions? If you have questions please contact the Emerson Hospital Connect Help Line at 978-287-7338.