Marino Center
for integrative health

MOUNT AUBURN HOSPITAL

NEW PATIENT PACKET

Please complete this form and bring any recent hospital, medical records, and lab tests, to your appointment.

PATIENT INFORMATION		
Patient Name:		Preferred:
Date of Birth:	Sex: (M/F/T)	Marital Status:
Home Address:		
Home Phone:	Mobile:	Other:
Email:	Type of Appointment reminder(s) you prefer: Phone Email Text	
Alternate Address:		

US DEPARTMENT OF HEALTH AND HUMAN SERVICES	
RACE: American Indian or Alaska Native Asian or Pacific Islander Black or African American Native Hawaiian White	
ETHNICITY: Hispanic Origin Not of Hispanic origin	Primary Language: Request Interpreter Services:

INSURANCE INFORMATION		
Insurance Company:		Subscriber:
Policy #:	Group Name:	Group #:
Date of Birth:	Sex:	Relationship:
Address:		
Secondary Insurance:		
Policy #:	Group Name:	Group #:

EMERGENCY CONTACT		
Contact Name:	Relationship:	Phone:

Primary Care Physician (PCP):		Phone:
Address:		
OTHER		
Employer:	Occupation:	Tenure:
How did you hear from us?	Travel time to office:	

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf directly to the Marino Center for any services furnished me. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medi-gap claim. I permit a copy of this authorization to be used in place of the original.

SIGNATURE DATE

Marino Center
for integrative health

Health History Form

MOUNT AUBURN HOSPITAL

These questions are designed to help us get to know you, and to make your first visit to the Marino Center more efficient and productive. THIS QUESTIONNAIRE IS FOR YOU. Many people find it helpful to organize their thoughts and make lists of important medical issues before seeing their practitioner. Feel free to skip any questions you do not find helpful, and do not include any information you would not want included in your medical record.

Your Name: _____ **Date of appointment:** _____

REASON FOR APPOINTMENT

Please describe your reason(s) for making this appointment and what you hope to accomplish in your initial visit:

CURRENT MEDICAL ISSUES

Please list any current medical issues you have, as well as the approximate date each problem or issue started:

PAST MEDICAL HISTORY

Please list important health problems or events in the past. Include any overnight hospitalizations (with approximate date) or significant medical studies or tests you have had:

Your Initials: _____

MEDICATIONS

Do you take any prescribed medications? Please list medications you take daily, as well as any medications you use "as needed". Include the dose and regimen (how often).

SUPPLEMENTS

Do you regularly take over-the-counter medications, herbs, vitamins, or other supplements? Please list supplements you take on a regular basis.

ALLERGIES

Please list any known medication allergies or sensitivities, including reactions you may have had in the past to medications.

FAMILY MEDICAL HISTORY

Please list your immediate "blood relative" family (Mother, Father, Siblings). Include their Year of Birth, note if they are deceased, (cause and year), and list any major medical problems they have. In particular, please note if they have a history of cancer, diabetes, heart disease under age 60, hypertension, or obesity

Your Initials: _____

SOCIAL HISTORY

Marital Status: Single / Partnered / Married / Separated / Divorced / Widowed

Spouse's name:

Children: (name, year of birth)

Your Occupation:

Company / Position:

Significant hobbies, activities or interests:

HEALTH HABITS

Do you use smoke or chew tobacco?	No	Cigarettes	Cigars	Pipe	Chew
If yes, how much do you use daily?					
What year did you start?					
If a past smoker, when did you quit?	For how long did you smoke?				

Do you drink alcohol?	No	Beer	Wine	Other		
About how much?	Rarely	"Social"	< 1 drink/day		Daily, 1-2 drinks	More

Please discuss any concerns you have about your alcohol intake with your practitioner.

Past or present recreational drug use, especially cocaine and IV drugs, can have important implications for your health. Please discuss recreational drug use with your practitioner at the time of your visit if this is an issue for you.

Your Initials: _____

Do you get regular exercise?

- Elite training regimen / intense exercise schedule
- Vigorous fitness program up to 5 times weekly
- Some vigorous exercise once or twice a week or "physical job"
- Try to be active / walk, take stairs
- Inactive, rarely exercise

Do you have a spiritual practice or stress-reduction technique that is important to you?

Meditation / Prayer / Organized religious affiliation / Yoga / Biofeedback / Other

Do you use complementary or alternative medical therapies for your health issues or Wellness?

Chiropractic	Acupuncture
Massage therapy	Yoga
Homeopathy	Reiki
Biofeedback	Other

HEALTH MAINTENANCE

Please bring to your appointment any records you may have about the following:

Immunization records
Mammogram (most recent)
Pap test (most recent)
PSA (prostate cancer screening) test
Colonoscopy
Cholesterol or other lab tests
Other tests or records pertaining to your current medical concerns

We look forward to meeting you at your initial Marino Center visit!

Marino Center
for integrative health

Patient Policies

MOUNT AUBURN HOSPITAL

Office Hours: Our regular office hours are Monday-Friday, 8am to 5pm & Saturdays 8am to 1pm.

Payment: Please check with your insurance company to see what services are covered by your policy. *You are responsible for confirming that your insurance will cover your treatment here.* If you are unable to provide us with your insurance information at the time of your visit, you will be asked to sign a NO EVIDENCE of COVERAGE waiver. Services not covered by your insurance must be paid at the time of the visit. We accept Master Card, Visa, Discover, American Express, personal checks, traveler's checks, and cash.

Referrals: If your insurance is an HMO or managed care plan, you must obtain a referral from your Primary Care Physician (PCP). As a member of managed care plan, I understand I have an obligation to have all medical care coordinated by my PCP. *I understand that I will be personally responsible for payment of services received if denied by my insurance carrier or if I do not have a referral from my PCP for any service dates.*

Lateness: Our practitioners try their best to be on time. Please be aware that if you are late, your appointment may need to be shorter, or we may need to reschedule it out of respect for the next patient.

Check In: Please check in at the Front Desk prior to all scheduled appointments so that your doctor will be alerted of your arrival. CHECK-IN does take some time even if you have visited us before; we recommend you arrive 10-15 minutes early.

Perfumes and Smoke: Because we treat environmentally sensitive patients, we respectfully request that you not wear perfume or aftershave to your visit. We also ask smokers not to smoke just before a visit; smoke stays on your person and can affect our allergic patients.

Parking: Free parking is available in the rear of our building on a first come first serve basis. Public parking is also available at nearby metered spaces.

Medical Records: By signing below you give the Marino Center authorization to allow sharing of information between your providers to include, but not limited to, consults, testing/laboratory services, and therapies. My signature also authorizes the Marino Center to mail directly to me pertinent office notes and test results on a limited basis as needed.

Research: The Marino Center is involved in a variety of research protocols. By signing below you are agreeing to be contacted about voluntary research studies that may be of interest to you. These opportunities are entirely optional and your decision to participate will not affect your care.

CANCELLATION and NO SHOW FEES

We require ***at least 24 hours' notice*** if you are canceling your appointment. For Monday appointments, you must cancel by the Friday before. **Cancellations less than 24 hours in advance will be charged the following fees:**

Primacy Care, Specialist Physician and Nurse Practitioner office visits are $25.00

Mental Health, Acupuncture, Chiropractic, Nutrition and Massage fees vary up to the full cost of the visit.
____ Patient Initials

I have read and I understand the office policies of the Marino Center.

Signature: _____ Date: _____

Print name: _____

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Marino Center for Integrative Health shares an integrated electronic medical record so that your caregivers at any affiliated site can provide you with high quality coordinated care. Access to the integrated medical record is expressly restricted to those clinicians and staff involved in your healthcare, or to those who need the information for payment or health care operations or other purposes as forth in this Notice. The privacy obligations of The Marino Center and your health information rights set forth in this Notice also apply to information maintained in the integrated medical record. Please review this notice carefully.

Our medical practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information or PHI). In conducting our practice of medicine, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. The Marino Center must provide you with the following important information: How we may use and disclose your PHI, your privacy rights in your PHI, our obligations concerning the use and disclosure of your PHI. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. If you have questions about this Notice, please contact: **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**

The following categories describe the different ways in which we may use and disclose your PHI: **Treatment**: We may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might disclose your PHI to a pharmacy when we order a prescription for you. Our practice staff, including, but not limited to, our physicians & nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment. **Payment**: We may use and disclose your PHI in order to bill and collect payment for the services and items that you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs such as family members. We may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. **Health Care Operations**: We may use and disclose your PHI to operate our business. As examples, our practice may use your PHI to evaluate the quality of care you receive from us or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. **Disclosures Required by Law**: We may disclose your PHI when we are required to do so by Federal, State, or local law. **Public Health Risks**: We may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of: Maintaining vital records, such as births and deaths; Reporting child abuse or neglect; Preventing or controlling disease, injury, or disability; Notifying a person regarding potential exposure to a communicable disease; Reporting reactions to drugs or problems with products or devices; Notifying individuals if a product or device they may be using has been recalled; Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence) however, we will only disclose information if the patient agrees or we are required or authorized by law to disclose this information; Notifying your employer under limited circumstances related primarily to workplace injury or illness, or medical surveillance. **Health Oversight Activities**: We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care systems in general. **Lawsuits and Similar Proceedings**: We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official regarding a crime victim in certain situations, if we are unable to obtain the person's

agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, subpoena or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator). **Deceased Patients:** We may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for the funeral directors to perform their jobs. **Organ and Tissue Donation**: We may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. **Research:** We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions: the use or disclosure involves no more than a minimal risk to your privacy based on the following: an adequate plan to protect the identifiers from improper use and disclosure; an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; the research could not practicably be conducted without the waiver; and the research could not practicably be conducted without access to and use of the PHI.
Serious Threats to Health or Safety: We may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. **Military:** We may disclose your PHI if you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities. **National Security:** We may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations. **Inmates:** We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; (c) to protect your health and safety or the health and safety of other individuals.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

You have the following rights regarding the PHI we maintain about you: **Confidential Communications:** You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**specifying the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable requests; you do not need to give a reason for your request. **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in or for the payment of, your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**Your request must describe in a clear and concise fashion including the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both, and to whom you want the limits to apply. **Inspection and Copies:** You have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including patient medical records and billing, but not including psychotherapy notes. You must submit your request in writing to **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**in order to inspect and/or obtain a copy of your PHI. *Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.*

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept at our practice. To request an amendment, your request must be made in writing and submitted to **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**You must provide us with a

reason that supports your request amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect or copy; (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. **Accounting Disclosure:** All of our patients have the right to request "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented; for example, the doctor sharing information with the nurse or billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**All requests for an accounting of disclosures must state a time period, which may not be longer than seven years from the date of disclosure and not include dates before January 1, 2004. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. **Right to a Paper Copy of this Notice:** You are entitled to receive a paper copy of our Notice of Privacy Practices.

To obtain a paper copy, contact **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646. Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Marguerite Herrie, Director of Operations, Mount Auburn Professional Services, 330 Mount Auburn St. Cambridge, MA 02138, (617) 499-5646.**All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Acknowledgement of the Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Marino Center for Integrative Health's Notice of Privacy Practices, which described how we use and disclose your health information. You have the right to refuse to sign this acknowledgement, in which case we must document our good faith effort to obtain acknowledgement and the reason it was not obtained. Reasonable efforts will be made to protect the privacy of your health information, whether it is maintained on paper or electronically, regardless of how it is communicated.

Receipt of Privacy Notice acknowledged by:

Print Name: _____ Date: _____

Signature: _____

Relationship to patient:

☐ Self ❒Other: _____

Patient, spouse, legal representative, or beneficiary: Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy plan.

OFFICE USE ONLY: Patient was given privacy notice, however:
Patient states that he/she has signed an acknowledgment form previously. Date: ____/____/_____
Patient refused or did not sign acknowledgement form. Date: ____/____/_____

Marino Center for Integrative Health
2500 Massachusetts Ave
Cambridge, MA 02141
www.marinocenter.org
Last updated October15, 2013

Authorization Form

(For Use or Disclosure of Protected Health Information)

In order for The Marino Center to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Reception Desk Staff.

Protected Health Information (PHI) is information that is created, received, transmitted, or stored by The Marino Center which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, The Marino Center may not use or disclose PHI to persons other than those you specify on this form.

To protect your PHI, we require those patients aged 18 years and older to complete and submit this form to the reception desk staff if you want someone other than you to have access to your PHI, pick up your prescriptions on your behalf, speak with your physician or Marino Center Staff on your behalf, or schedule appointments on your behalf.

Print Name of Individual/Patient (if authorizing below) _____

ALL OF THE FOLLOWING PARTS MUST BE COMPLETED

PART I: Authorized Person(s)

I authorize The Marino Center to disclose the PHI identified in Part II of this form to the following person(s):

Please designate person(s) and fill in their names. These individuals will need to show a picture ID if picking up prescriptions, or collecting written documents on your behalf.

☐ **Spouse** _____
(Print Spouse's Name)

☐ **Other Designee**: _____
Relationship: _____

PART II: Description of the information to be used or disclosed:
I authorize The Marino Center todisclose PHI (including written, electronic, or oral information) to the person(s) identified in PART I of the form in connection with **(mar**k **al**l **tha**t **apply)**.
This includes prescription inquiries/pick up and appointment scheduling / information.
I understand that if I want different people to have access to different information, I must complete a separate form accordingly.

Prescriptions pick up or request

Appointment Scheduling or inquiries

Immunization record history

Lab results / other testing and imaging

Office Visits: _____ (identify)

Entire PHI (Complete access to all information in my record)

PART III: Purpose of use or disclosure *(mark all that apply)*

Personal

Disease Management

Student Limitations

Travel Limitations

PART IV: Validity of Form
This authorization form is valid for the one year from signature date or when:
I cancel the authorization by completing a Cancellation of Authorization Form.

Name: _____ Date: _____

PART V: Acknowledgement and Signature that:

I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM
I HAVETHE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE RECEPTION DESK
CANCELLATION WILL TAKE EFFECT ONCE THE RECEPTION DESK RECEIVES THE SIGNED FORM

_____ _____
Your Signature (or Signature of PersonalRepresentative) Date

*If you are acting as the Personal Representative of the individual whose PHI isto be disclosed, you must provide proof of your authority or act for that individual.

Marino Center
for integrative health

MOUNT AUBURN HOSPITAL

Directions to the Marino Center

The Marino Center for Integrative Health is located at **2500 Massachusetts Avenue Cambridge, MA 02140**. Free parking is available underneath the Center. Metered spaces are available on the street.

By Car

From Points South:
Take Route 128 North to Route 2 East (exit, Cambridge/Arlington). Continue on Route 2 and head East on Route 16 (towards Medford) for 1/2 miles until the next traffic light. Turn right at light onto Massachusetts Avenue and proceed about 300 yards. The Marino Center is located on the right.

From Points North:
Take Route 93 South to Route 60 (Medford) and proceed through Medford Square, bearing left. Take next right onto Route 16 West (Mystic Valley Parkway). Proceed three miles and take a left onto Massachusetts Avenue. The Marino Center is approximately 300 yards down on the right.

From Points West:
Take the Mass. Pike to Route 128 North. Follow directions from Points South.

By Public Transportation

Red Line to Davis Square T-Station:
Take street-level exit on left to paved footpath. Follow path through a small park, across street, back onto path. Go through gates, across street, through sitting area to Massachusetts Avenue and turn right. Proceed two blocks on Massachusetts Avenue to Bright Horizons Day Care Center. The Center is across the street.

Bus Line:
Take the #77 bus from Harvard Square or Arlington Center. From Harvard Square, the bus stops across the street from the Center.

Main Number: 617-661-6225

SERVICES	EXTENSION	MEMBERS
Primary Care	6801	Dr. Guy Pugh & Dr. Hiromichi Miyashita
Primary Care	6802	Dr. Prachi Joshi & Dr. Selma Holden
Primary Care	6807	Dr. Dianne Munson & Dr. Beatriz Talayero
Primary Care	6804	Dr. Caren Eliezer
Holistic – Pain Management	6802	Dr. Leonid Gordin
Nutrition	6808	Susan Carroll
Mental Health	6808	Dr. David Anick
Rheumatology	6804	Dr. Lucille Shore-Schein
Women's Health	6803	Deb Morrill, Nancy Bartleson Sarah Hall, Donna George
Nursing / Triage	6810	Caroline, Kris, Regina, Vivian, Janice
Complementary Medicine		
Acupuncture	6805	Ping Yao LiAc

Chiropractic		Dr. Al Maalouf
Herbal Medicine		Ping Yao LiAc
Massage		Steve Genduso LMT & Regina Fox RN LMT
Administration		
Billing	617-499-5488	Mount Auburn Hospital Billing
Referrals	6999	Christine
Medical Records	7110	Yessica