Women's Medicine Collaborative

A program of The Miriam Hospital

Lifespan. Delivering health with care.™

146 West River Street
Providence, RI 02904
(401) 793-5700
WomensMedicine.org

Dear _____,

Welcome to the **Women's Medicine Collaborative.**

Your appointment is on _____ at _____ am/pm

with _____ of _____

on the _____ floor.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time for registration. If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance. Please call us at (401) 793-5700 if you have any questions.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

For more information about the Women's Medicine Collaborative, please visit our website at *www.WomensMedicine.org.*

We look forward to seeing you.

Sincerely,
Women's Medicine Collaborative

"Helping women reach their greatest health potential in body, mind, and spirit."

Women's Medicine Collaborative
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*The Miriam Hospital d b.a. Women's Medicine Collaborative

146 West River Street
Providence, RI 02904

Tel 401 793-5700
Fax 401 793-7801

About Your Billing

To our patients:

This letter is to give you notice that the Women's Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor's office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women's Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible:
The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.

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2nd Floor - Bone Density Testing, Pulmonary Function Testing, Lifestyle Medicine Center, Acupuncture, Chiropractic Care, Massage Therapy, Nutrition, Stress Reduction, Yoga, Lifespan Laboratory

3rd Floor - Behavioral Medicine, Bone Health, High-Risk Breast Program, Cancer Survivorship, Cardiology, Colposcopy Clinic, Diabetes in Pregnancy, Gastrointestinal Medicine, Genetics, GYN Oncology, Menopause Consultation, Maternal-Fetal Medicine, Obstetric Medicine, Program for Pelvic Floor Disorders , Pelvic Pain Program, Primary Care, Pulmonary Medicine, Rheumatology, Urology, Urogynecology

Directions

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 146 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

BUS ROUTES

Best service to take is **Route# 51, 52 or 72** to Charles Street and West River Street. Route 51 runs every half hour. Route 52 and 72 both run every 45 minutes or so. Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter into the South parking lot entrance. Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

02/2017

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*The Miriam Hospital d.b.a. Women's Medicine Collaborative

146 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Mobile Phone ( )

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated
❑ Widowed ❑ Significant Other ❑ Other:_____

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male

Religion: _____

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone ( )

Which provider you are here to see today?

How did you hear about us?

Primary Care Provider (PCP) / Practice Name

PCP Address

PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the Women's Medicine Collaborative Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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Patient Label

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: _____

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (_____) _____

MOBILE telephone # (_____) _____

WORK telephone # (_____) _____

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a general message about appointments? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a detailed message? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

Rev. 02/2017

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Cancer Survivorship Program Visit Assessment

Patient Label

PATIENT _____ DOB ____/____/____ Today's Date: ____/____/____

Translator needed? ☐ No ☐ Yes - Preferred Language Spoken: _____ Written: _____

Who is your Medical Oncologist? _____ Radiation Oncologist? _____ Surgeon? _____

As part of your visit you are asked to answer the following questions. If you have any issues of concern, the physician will assist you with further evaluation questions so that we may develop a more complete plan of care for you.

Pain

1. Are you having any pain? ☐ Yes ☐ No
2. How would you rate your pain on a scale of 0 (none) to 10 (extreme) over the past month? ____ (0-10)

Healthy Lifestyle

1. Do you engage in regular physical activity or exercise, such as brisk walking, jogging, bicycling, swimming, etc.? ☐ Yes ☐ No

1a. If you answered yes, how often?

☐ less than 30 minutes per week ☐ 30-59 minutes per week ☐ 60-89 minutes per week
☐ 90-150 minutes per week ☐ greater than 150 minutes per week

2. Excluding white potatoes, do you eat at least 2 ½ cups of fruits and/or vegetables each day? ☐ Yes ☐ No
3. Do you have concerns about your weight? ☐ Yes ☐ No
4. Do you take vitamins or supplements? ☐ Yes ☐ No
5. During the past 30 days, did you diet to lose weight or to keep from gaining weight? ☐ Yes ☐ No
6. Do you have any limitations to participating in the physical activities that you enjoy? ☐ Yes ☐ No
7. Do you currently smoke? ☐ Yes ☐ No If NO, have you ever been a smoker? ☐ Yes ☐ No
8. How many alcoholic drinks do you usually have per week? (1 drink = 12 oz. beer, 5 oz. wine, or 1.5 oz. liquor)

Circle: None 1 2 3 4 5 6 7 More than 7

Fatigue

1. Do you feel persistent fatigue despite a good night's sleep? ☐ Yes ☐ No 2. Does fatigue interfere with usual activities? ☐ Yes ☐ No
3. How would you rate your fatigue on a scale of 0 (none) to 10 (extreme) over the past month? _____ (0-10)

Sleep Disorder

1. Are you having problems falling asleep or staying asleep? ☐ Yes ☐ No
2. Are you experiencing excessive sleepiness (such as sleepiness or falling asleep in inappropriate situations or sleeping more during a 24-hour period than in the past)? ☐ Yes ☐ No
3. Have you been told that you snore frequently or that you stop breathing during sleep? ☐ Yes ☐ No

Cardiac Toxicity

1. Did you receive anthracycline therapy, such as doxorubicin, epirubicin, daunorubicin, or AC (doxorubicin + cyclophosphamide)? ☐ Yes ☐ No
2. Do you have shortness of breath or chest pain after daily activities (such as walking upstairs) or exercise? ☐ Yes ☐ No
3. Do you have shortness of breath while lying flat, wake up at night needing to get air, or have persistent leg swelling? ☐ Yes ☐ No

Anxiety, Depression, and Distress

1. Over the past 2 weeks have you been bothered more than half the days by little interest or pleasure in doing things? ☐ Yes ☐ No
2. Over the past 2 weeks have you been bothered more than half the days by feeling down, depressed, or hopeless? ☐ Yes ☐ No
3. Over the past 2 weeks have you been bothered more than half the days by not being able to stop or control worrying, or have you felt nervous or on edge? ☐ Yes ☐ No

Cognitive Function

1. Do you have difficulties with multitasking or paying attention? ☐ Yes ☐ No
2. Do you have difficulties with remembering things? ☐ Yes ☐ No 3. Does your thinking seem slow? ☐ Yes ☐ No

Sexual Function

1. Do you have any concerns regarding your sexual function, sexual activity, sexual relationships, or sex life? ☐ Yes ☐ No
2. Are these concerns causing you distress? ☐ Yes ☐ No

Immunizations & Infections

1. Have you received the flu vaccine this flu season? ☐ Yes ☐ No 2. Are you up to date on your vaccines? ☐ Yes ☐ No ☐ Unsure

Menopause

1. Have you been bothered by hot flashes/night sweats? ☐ Yes ☐ No
2. Have you been bothered by other menopause-related symptoms (such as vaginal dryness or incontinence)? ☐ Yes ☐ No

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Patient Label

Cancer Survivorship Program
Health Screening Questionnaire

PATIENT _____ DOB _____ /_____ /_____

Today's Date: _____ /_____ /_____

1. Who orders your screening tests & lab work? _____

2. Have you had a Pap smear screening? ☐ Yes ☐ No

   If YES, when was your most recent Pap smear?_____

   Do you know the result? ☐ No ☐ Yes: _____

3. Have you had your mammogram? ☐ Yes ☐ No

   If YES, when was your most recent mammogram? _____

   Do you know the result? ☐ No ☐ Yes: _____

4. Have you had a colonoscopy? ☐ Yes ☐ No

   If YES, when was your most recent colonoscopy? _____

   Do you know the result? ☐ No ☐ Yes: _____

5. Have you had a CT scan? ☐ Yes ☐ No

   If YES, when was your most recent CT scan? _____

   Do you know the result? ☐ No ☐ Yes: _____

6. Have you received any vaccinations recently? ☐ Yes ☐ No

   If YES, which one(s)? _____

7. Have you received the Zoster (Shingles) vaccine? ☐ Yes ☐ No

   If YES, when? _____

8. Have you talked to a genetic counselor? ☐ Yes ☐ No

9. Have you had genetic counseling? ☐ Yes ☐ No

10. Are you interested in a genetic counseling appointment? ☐ Yes ☐ No