Women's Medicine Collaborative
A program of The Miriam Hospital
A Lifespan Partner

Genetic Counseling
146 West River Street
Providence, RI 02904
3rd Floor ~ Suite 11-D
401 793-7410

Chanika Phornphutkul, MD
Cindy Benson, MS (Senior Genetic Counselor)
Jennifer Schwab, MS (Genetic Counselor)

Welcome to the Women's Medicine Collaborative. We look forward to meeting with you.

Information for your first visit:

- Your appointment is on ____________________ at __________________ am / pm.
- Enclosed you will find directions to the Women's Medicine Collaborative.
  Please allow yourself enough time to arrive 15 minutes before your appointment.
- There is free parking in the South parking lot. The elevators are to the left as you enter the building. Take the elevator to the 3rd floor; and enter our suite using the door on your far left.

To reschedule or cancel your appointment,
please call (401)793-7410 at least 24 hours in advance.

For specific questions about what will be covered during your visit,
please call (401) 444-8361.

Before your visit

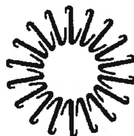
- Please complete the enclosed questionnaire.
- Take time to write down any questions or concerns you have.

Bring to your visit

- The completed questionnaire
- Your list of questions and concerns
- Your insurance card(s)
- Photo identification
- Any important medical information, list of medications you take, names of medical specialists you see

We look forward to seeing you.

Sincerely,
Women's Medicine Collaborative



Women's Medicine Collaborative*

Lifespan. Delivering health with care.™

*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

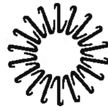
Definitions

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)

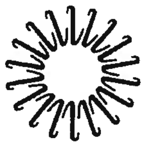
Park in the South parking lot.

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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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	Subscriber's Employer
❑ Full Time ❑ Part Time ❑ Unemployed	

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

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

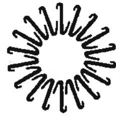
IN CASE OF EMERGENCY

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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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

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FAMILY HISTORY FORM

Name: ______________________________ **Age:**________ **DOB:**__________________
Appointment Date: ____/____/____ **Time:** __________**am/pm**

****Please bring this form to your appointment.****

Address:____
Home Phone: ________________________ **Cell Phone:** __________________________

YOUR History:

Current Medications	Current Medical Conditions/Illnesses	Past Illnesses/Hospitalizations/Surgery

Have you ever had problems with:
Eyes, ears, nose or throat? ❑ No ❑ Yes:____________________ Skin? ❑ No ❑ Yes:__________________
Heart? ❑ No ❑ Yes:____________________ Lungs/asthma? ❑ No ❑ Yes:__________________
Muscles? ❑ No ❑ Yes:____________________ Depression/Mental Illness? ❑ No ❑ Yes:______________
Seizures? ❑ No ❑ Yes:____________________ Learning problems? ❑ No ❑ Yes:__________________

Do you smoke? ❑ No ❑ Yes If yes, how many cigarettes/packs per day?_____________
Do you drink alcohol (beer, wine, liquor)? ❑ No ❑ Yes If yes, how many drinks per day or week?____per day/week

Education completed (years or degree):______________ Occupation: ____________________________
Religion:______________________ Ethnicity/Countries of Origin: ____________________________
Are you of Ashkenazi (Eastern or Central European) Jewish decent? ❑ No ❑ Yes

YOUR Parents:

	Full Name	Age	Living?	Major Illness(es) or Cause of Death
Mother			❑ Yes ❑ No	
Father			❑ Yes ❑ No	

YOUR Brothers/Sisters: Please list all brothers and sisters, including half-brothers or half-sisters from either parent.

Full Name	Age	Living?	Major Illness(es) or Cause of Death
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	

YOUR Children: Please list all children from past and present partners.

Full Name	Age	Major Illness(es) and/or Learning Problems

Have you ever had miscarriages, abortions, stillbirths and/or deceased children? If yes, please list and indicate year: ______________________________

Family History: Thinking about all of your BLOOD relatives from your mother and father's family, please indicate if anyone has/had any of the following. If yes, please write their relationship to you. For example: mother's cousin, father's aunt, etc.

Condition			Relationship to You	
Genetic Disorder	❑ No	❑ Yes		
Family Genetic Testing	❑ No	❑ Yes		Test Results:
Mental Retardation or Intellectual disability	❑ No	❑ Yes		
Learning problems / Developmental delay	❑ No	❑ Yes		
Neurological problems (seizures, migraines, tremors, etc.)	❑ No	❑ Yes		Describe:
Birth Defect	❑ No	❑ Yes		Describe:
Skin problem / Skin Cancer	❑ No	❑ Yes		
Muscle weakness	❑ No	❑ Yes		Age Started______
Heart disease	❑ No	❑ Yes		
Thyroid problem	❑ No	❑ Yes		
Gastrointestinal (stomach) problem	❑ No	❑ Yes		
Multiple bone fractures	❑ No	❑ Yes		
Mental Health disorder	❑ No	❑ Yes		
Memory Loss / Dementia	❑ No	❑ Yes		
Other	❑ No	❑ Yes		Describe:

Cancer Family History: Thinking about all BLOOD relatives from your mother and father's family.

Condition			Relationship to You	
Breast cancer	❑ No	❑ Yes		
Ovarian cancer	❑ No	❑ Yes		
Colorectal cancer or # of Polyps	❑ No	❑ Yes		
Endometrial cancer	❑ No	❑ Yes		
Pancreatic cancer	❑ No	❑ Yes		
Melanoma	❑ No	❑ Yes		
Multiple cancers in the same individual	❑ No	❑ Yes		
Other cancer	❑ No	❑ Yes		Describe:

Please list any questions you would like answered (attach another sheet if necessary):