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

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

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

High Risk Breast Program
146 West River Street, Providence, RI 02904
3rd Floor ~ Suite 11D
401 793-7917

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A program of The Miriam Hospital
A Lifespan Partner

Patient Label

MEDICAL HISTORY QUESTIONNAIRE

PLEASE FILL OUT ALL FORMS AND BRING TO YOUR APPOINTMENT
Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: _____ First: _____ DOB: _____
Preferred Language Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Your Physicians
Primary Care Provider_____ Date last seen: _____
GYN Provider_____ Date last seen: _____
Other Providers/Specialists:
Name _____Specialty_____ Date last seen: _____
Name _____Specialty_____ Date last seen: _____
Name _____Specialty_____ Date last seen: _____
Which provider referred you to see us? _____
Briefly describe the reason for your referral and your current symptoms:

List all MEDICATIONS (please include non-prescription drugs)

Medication	Dose	Frequency	Reason you take this

Do you take any blood thinning medications (such as Coumadin (Warfarin), Lovenox (Enoxaparin), Heparin) or aspirin?
If yes, which medications and how often? _____

List all ALLERGIES:

Medication/Food	Reaction

Past Medical History (please check all that apply)

□ Diabetes (including gestational) □ High Blood Pressure □ Heart Attack □ Stroke □ Blood Clot
□ Kidney Disease □ Liver Disease □ Thyroid Disease □ Seizures □ Asthma
□ Anemia □ Depression □ Anxiety
□ Bleeding tendency (describe): _____
□ Problems receiving anesthesia (describe): _____
□ Cancer (type) _____ □ Other _____

Screenings

Colonoscopy: Date: _____ Result: _____
Last Mammogram: Date: _____ Result: _____

Surgical History (please list procedure and date)

_____ _____
_____ _____
_____ _____

Have you ever received a blood transfusion? □ Yes □ No If yes, year _____
Have you had a hysterectomy? □ Yes □ No If yes, reason _____
Were your ovaries removed? □ No □ Yes (one) □ Yes (both)

OB/GYN HISTORY:

Number of pregnancies: _____ Number of live births: _____ Miscarriages: _____ Abortions: _____
Last menstrual period: _____ Age at first period: _____ Occurs every ____ days
Any abnormal bleeding ? □ No □ Yes (describe) _____
Age at menopause: _____ □ N/A
Birth Control: □ used in the past □ currently use (type) _____
Hormone Replacement Therapy: □ used in the past □ currently use (type) _____
Last Pap smear: _____ Result: _____
Any abnormal PAP smears in the past? □ No □ Yes

Lifestyle and Personal Habits

Who do you live with at home? _____ Your occupation _____
Do you/have you ever smoked cigarettes? □ Yes □ No If yes, _____ packs/day for _____years Quit date _____
Do you drink alcohol? □ Yes □ No If yes, number of drinks/week _____
Do you use any recreational drugs? □ Yes □ No If yes, what type? _____
Have you ever been treated for problems with alcohol or drugs? □ Yes □ No

Cancer Family History

Thinking about <u>all</u> 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	
Breast cancer	❑ No	❑ Yes		
Ovarian cancer	❑ No	❑ Yes		
Uterine cancer	❑ No	❑ Yes		
Endometrial cancer	❑ No	❑ Yes		
Colorectal cancer	❑ No	❑ Yes		
Other cancer	❑ No	❑ Yes		Describe:

The Miriam Hospital
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The Miriam Hospital
Health Information Management
164 Summit Avenue
Providence, RI 02906
Ph) 401-793-2222 Fax) 401-793-2247

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name_____ DOB_____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize The Lifespan Hospital /Women's Medicine Collaborative to: ☐ Release to and/or ☐ Obtain from

2. _____ _____
Person /Place/Institution Phone Number

_____ _____
Street City State ZIP Fax Number

3. Dates of treatment or time period: _____

4. Purpose for which disclosure is to be made: ☐ Coordination of Care ☐ Patient Request ☐ Legal

☐ Other (please specify): _____

5. Record Format-please check one: ☐ paper ☐data storage device

6. Information to be disclosed (check all applicable): *There may be a fee associated with this request.*

☐Emergency Dept. Record ☐Operative/Path Report ☐Lab/X-ray Reports ☐Other Diagnostic Testing

☐Clinic/Office Visit ☐Consultation/Evaluation ☐After Visit Summary

☐Abstract* ☐Discharge Summary ☐Other_____

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT/OT/ST

For Behavioral Health Affiliates: ☐Assessment ☐Treatment Plan ☐Psychiatric Evaluation ☐ Medications

7. I do not want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test

☐sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.

9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

_____ _____
Signature of Patient*, Legal Guardian, or Representative Date Time

_____ _____
Print name of Patient, Legal Guardian or Representative Date Time

*Note Concerning Minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required.