



Women's Medicine Collaborative

A program of The Miriam Hospital
A Lifespan Partner

146 West River Street
Providence, RI 02904
(401) 793-7020
WomensMedicine.org

Date _____

Dear _____,

Welcome to Women's Behavioral Medicine at the Women's Medicine Collaborative.

Your appointment is on _____ at _____ am/pm
with _____ of Women's Behavioral Medicine on the 3rd floor.

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

Please do not mail your packet back to us.

Please arrive 20 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) 793-7020 if you have any questions. Please Note: If you arrive more than 15 minutes late, it is possible you may not be seen.

We are an outpatient program specializing in the treatment of women who are struggling with mood and anxiety disorders. While in treatment here, we may recommend that you participate in a combination of individual psychotherapy and/or medication management for your symptoms. If medications are needed and recommended, the prescribing doctor will review the medication options with you. If you have further questions or you are experiencing side effects, contact your clinician at (401) 793-7020. Please be aware that if your clinician feels you need further assessment, you may be referred to another facility for crisis evaluation, such as an emergency room. Similarly, if a family member has a question or concern, they can contact your clinician during or after business hours if the concern is emergent by calling (401) 793-7020.

We are glad you are here. Because we want you to feel better, your ongoing care is important to us. In order to facilitate this, it is vital that you keep all of your appointments. Multiple missed or canceled appointments may result in discharge of your care. We welcome any questions or comments that you or your family may have regarding your treatment.

Directions are on the reverse side of this letter. Park in the South parking lot. Parking is free.

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

We look forward to seeing you.

Sincerely,
Women's Behavioral Medicine

05/03/2017

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



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

About Your Billing

Tel 401 793-5700
Fax 401 793-7801

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

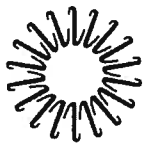
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

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.



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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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Significant Other <input type="checkbox"/> Other: _____		Preferred Language Spoken: _____ Written: _____ Interpreter Required? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Religion: _____	
Preferred Pharmacy: Name: Address:		Phone #:	
Are you Employed? <input type="checkbox"/> YES, Full Time <input type="checkbox"/> YES, Part Time <input type="checkbox"/> YES, Self-employed <input type="checkbox"/> Student, Full Time <input type="checkbox"/> NO, Not Employed <input type="checkbox"/> NO, Disabled <input type="checkbox"/> NO, Retired <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Insurance Plan Name		
Group #	Policy #		Co-Pay Amount
Subscriber's Name		Subscriber's Birth Date / /	Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Subscriber's Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed		Subscriber's Employer	
Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #
Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Subscriber's Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> 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

Name _____ Date of Birth _____
WOMEN'S BEHAVIORAL MEDICINE PATIENT QUESTIONNAIRE
PSYCHIATRIC/MEDICAL HISTORY DATE: _____

Name _____ DOB _____ Age _____

Please answer each of the following questions. Thank you.

Please describe the reason(s) why you are seeking treatment: _____

Please list any previous outpatient psychiatric/alcohol/substance abuse treatment: None
Date Therapist/MD Reason Did it help?

Please list any previous psychiatric/alcohol/substance abuse hospitalizations: None
Date Therapist/MD Reason Did it help?

Please list any psychiatric medications you are taking **NOW**. None

Drug	Dose	Frequency	Reason/Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any psychiatric medications you have taken in the **PAST**. None

Drug	Dose	Frequency	Reason/Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please complete the information requested below about your medical history.

Primary Physician's Name: _____ Phone Number: _____
Date of last physical exam: _____ Any problems? No Yes, Describe: _____

Date of most recent routine blood tests: _____ Date of most recent thyroid screen blood test: _____

Obstetrician/Gynecologist's Name: _____ Phone Number: _____
Date of last pelvic exam: _____ Any problems? No Yes, Describe: _____

Date of most recent mammogram: _____

Name _____ Date of Birth _____

Other Physicians:

Gastroenterologist _____

Endocrinologist _____

Other (please specify) _____

REVIEW OF SYSTEMS

What is your height? _____

What is your weight? _____

General: fever sweats appetite change problems sleeping

Eyes: eye pain glaucoma double vision blurred vision

Ears/Nose/Mouth/Throat: hearing loss nosebleeds sinus trouble sore throat

Breasts: pain lumps nipple discharge

Respiratory: shortness of breath wheezing cough coughing up blood

Cardiovascular: chest pain palpitations heart murmur swelling in legs

Gastrointestinal: abdominal pain constipation diarrhea bloating/gas rectal bleeding heartburn

Genitourinary: frequent urination painful urination blood in urine incontinence irregular bleeding
 vaginal dryness vaginal discharge painful intercourse

Musculoskeletal: joint pain/stiffness muscle aches back pain leg cramps with walking

Skin: varicose veins moles changing rash

Neurological: numbness/tingling tremor dizziness memory changes headaches

Hematologic/Lymphatic: easy bruising blood clot anemia swollen lymph glands

Endocrine: increased thirst feeling cold/hot hot flashes weight change: gain/loss _____ lbs

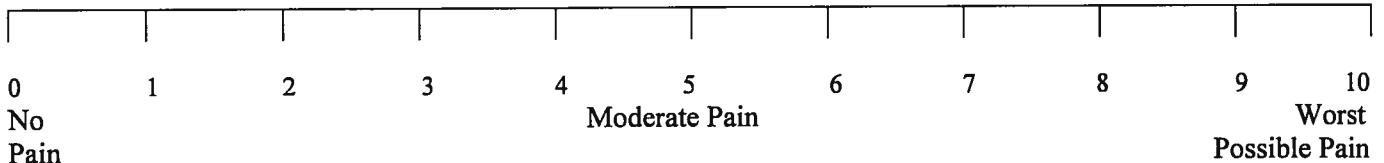
MEDICAL HISTORY (Please check all that apply)

- High Blood Pressure Diabetes (including gestational) Stroke High cholesterol Heart Attack
- Asthma Pneumonia Emphysema Tuberculosis Kidney Disease Thyroid Disease
- Ulcers Liver Disease Migraine Arthritis Osteoporosis Fractures
- Bleeding Tendency Anemia Blood Clot Seizure Frequent UTI
- Sexually Transmitted Disease HIV/AIDS Ovarian cysts Fibroids
- Cancer: Type _____ Other _____

Do you typically have pain ? No Yes

If yes: Where _____ How often? _____ Treatment? _____

How much pain are you in on average over the last week? (please circle)



Name _____ Date of Birth _____

Pharmacy name, address and phone number: _____

Do you have any allergies or sensitivities to medication or environmental factors? None
Substance _____ Allergic Reaction or Sensitivity _____ Mild/Moderate/Severe _____

Have you ever been evaluated by a neurologist? No Yes Date: _____
Have you ever had an EEG (brain wave)? No Yes Date: _____
Have you ever had an MRI of the head? No Yes Date: _____
Have you ever had a CT Scan of the head? No Yes Date: _____

Please list current medical problems and specialists you currently receive treatment from. None
Problem _____ Physician Name/Specialty _____ Phone Number _____

Have you had previous hospitalizations for medical or surgical problems? None
Date _____ Problem _____ Hospital _____ Physician _____

Date	Problem	Hospital	Physician

Please list any non-psychiatric medications you are currently taking. None

Drug	Dose	Frequency	Prescriber/Date Started

OB/GYN HISTORY

Are you pregnant now? No Yes How many weeks? _____
Due Date? _____

Are you currently breastfeed, or if pregnant, do you plan to breastfeed? No Yes

Have you ever been pregnant? No Yes # of Pregnancies _____

Have you ever had a miscarriage? No Yes When? _____

Have you ever terminated a pregnancy? No Yes When? _____

Do you have regular menstrual periods? No Yes Last Menstrual Period: _____

Do you have any pain or problems associated with your period? No Yes

Do you have any emotional symptoms before your period that resolve after it starts? No Yes

Do you have any signs or symptoms of menopause? No Yes - Please circle:

Hot flashes night sweats vaginal dryness irregular periods broken sleep

LIFESTYLE/PERSONAL HABITS

Educational History:

Level Achieved (e.g. high school, GED, graduate school)

Degree Earned/Major/Area of Interest

Occupational History:

Job Titles

Dates

Military service? No Yes, _____

Religion _____ Current Spiritual Orientation _____

Who do you live with at home? _____

Do you exercise regularly? No Yes

Do you follow a special diet? No Yes (please describe) _____

Please list hobbies/interests: _____

Do you drink alcohol? No Yes – Amount/Frequency _____

Do you smoke cigarettes? No Yes – Amount/Frequency _____

If no, did you ever smoke? No Yes – Ages ___ - ___

Do you use electronic cigarettes? No Yes – Amount/Frequency _____

Do you use smokeless tobacco? No Yes – Amount/Frequency _____

Do you use any recreational drugs? No Yes – if yes: Type: _____

Amount: _____

Frequency: _____

Do you feel safe at home at present? No Yes

Is anyone physically hurting or threatening you? No Yes

Is anyone hitting, kicking, or choking you? No Yes

Is anyone forcing you to do something sexually? No Yes

Do you have guns in your home? No Yes

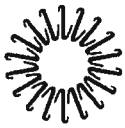
FAMILY PSYCHIATRIC HISTORY

Has anyone in your family ever had a psychiatric, alcohol or other substance abuse problem? None

Family Member (e.g., Parent, sibling, aunt, grandmother, etc.) Problem

Reviewed by _____ Date _____

11/28/2017



Patient Label

Name: _____ DOB: _____ Date: _____

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

	In the past 12 months	Yes	No
1	Have you ever felt that you ought to cut down on your drinking or drug use?		
2	Have people annoyed you by criticizing your drinking or drug use?		
3	Have you ever felt bad or guilty about your drinking or drug use?		
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

	Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
	<i>Add the score for each column</i>				
	<i>Total Score (add your column scores) =</i>				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	



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Patient Label

**Patient Health Questionnaire-9
(PHQ 9)**

Over the last 2 weeks how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office Coding 0 + + +
= Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all Somewhat difficult Very difficult Extremely difficult
-



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Patient Label

Women's Behavioral Medicine

Dear Patient:

Since you may be receiving care from more than one source, it is important to make sure that the different plans of care do not duplicate one another or conflict with one another. Generally your primary care physician would expect to know about the treatment provided by each person treating you, including your psychiatrist and/or therapist. We recommend that you give us permission to communicate with your primary care, ob/gyn, therapist or other provider, but we will not do so without your permission. The reverse of this page shows the kind of information we would be sending. Please complete the information below.

I allow Women's Behavioral Medicine to communicate with my: (please check below and provide provider name)

___ Primary care provider	(Name)	_____
___ Ob/Gyn	(Name)	_____
___ Therapist	(Name)	_____
___ Other provider	(Name)	_____

- I do not have a primary care provider, Ob/Gyn, therapist, or other provider
- I do not want you to communicate with my health care provider except in an emergency
- I give you permission to send the letter on the reverse of this page to my health care provider(s) listed above and I also authorize him/her to communicate with you.

I understand that my records are protected under RI General Law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve drug or alcohol abuse, they are also protected under Federal Regulation 42 CFR Part 2.

I herein expressly and voluntarily consent to disclosure of the specified information including alcohol and drug abuse diagnosis and treatment and HIV (AIDS) testing.

I further release The Miriam Hospital dba Women's Medicine Collaborative and its employees from any liability arising from the release of this information, provided said release of information is done substantially in accordance with applicable law.

This authorization will expire in one year. I may revoke my consent at any time except insofar as action has been taken in reliance on it. A photocopy or facsimile of this release will be considered as good as the original.

_____	_____	_____
Patient	Date	Time
_____	_____	_____
Parent or Legal Guardian	Date	Time



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Dear Dr. _____

Re: Name _____ DOB _____

This is to let you know that I evaluated your patient for psychiatric medication management psychotherapy,
and am providing you with you some basic clinical information.

This visit is a consult only. I will be providing ongoing treatment.

First Evaluated: _____

Current Diagnosis: _____

Comments and Cautions: _____

Sincerely,

Women's Behavioral Medicine
Women's Medicine Collaborative



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INFORMATION FOR PATIENTS

PROCEDURE FOR MEDICATION REFILLS

When you are prescribed medication by a physician from Women's Behavioral Medicine at the Women's Medicine Collaborative, you are generally prescribed enough medication to last until your next scheduled appointment. If you need a refill of your medication prior to your next appointment, please follow the procedure below to avoid an interruption in medication:

Check your prescription bottle or check directly with your pharmacy to see if additional refills are already authorized.

If additional refills are not authorized, call your pharmacy and ask them to request refills from your doctor electronically or by fax to (401) 793-7407. You may also call Women's Behavioral Medicine at (401) 793-7020 with the following information.

- Your name, date of birth and telephone number
- Name(s) and dosages(s) of the medication(s) needed
- Directions for taking the medication (number of times you take the medication per day)
- Number of doses of medication remaining
- Name and phone number of your pharmacy

Please remember that refills are only called in for current patients actively in treatment with a physician from Women's Behavioral Medicine. Generally, enough medication is called into the pharmacy to last until your next scheduled appointment.