

## 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.

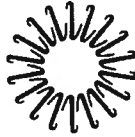
***Driving directions are enclosed.*** Park in the South parking lot. Parking is free.

For more information about the Women's Medicine Collaborative, please visit our website at [www.WomensMedicine.org](http://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

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

**3<sup>rd</sup> 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**

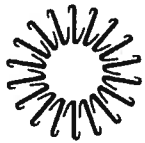
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

**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](http://www.ripta.com) for schedules and additional information.



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146 West River Street, Providence, RI 02904

Patient Label
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**REGISTRATION FORM**

<b>PATIENT INFORMATION (PLEASE PRINT)</b>					
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 (    )	
<b>INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST</b>					
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	
<b>IN CASE OF EMERGENCY</b>					
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

**High Risk Breast Program**

146 West River Street, Providence, RI 02904

3<sup>rd</sup> Floor ~ Suite 11D

401 793-7917



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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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

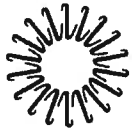
**Lifestyle and Personal Habits**

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 all 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Ovarian cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Uterine cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Endometrial cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Colorectal cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Other cancer	<input type="checkbox"/> No	<input type="checkbox"/> 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.