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.”
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.
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
**REGISTRATION FORM**

**PATIENT INFORMATION (PLEASE PRINT)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Social Security #</th>
<th>Email</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Mobile Phone</th>
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</table>

**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:** ______________________________
- **Address:** ______________________________
- **Phone #:** ______________________________

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

**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

<table>
<thead>
<tr>
<th>Group #</th>
<th>Policy #</th>
<th>Co-Pay Amount</th>
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<table>
<thead>
<tr>
<th>Subscriber’s Name</th>
<th>Subscriber’s Birth Date</th>
<th>Patient’s relationship to subscriber</th>
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<tbody>
<tr>
<td></td>
<td>/ /</td>
<td>[ ] Self [ ] Spouse [ ] Child</td>
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<td></td>
<td></td>
<td>[ ] Other</td>
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<tr>
<th>Subscriber’s Employment Status</th>
<th>Subscriber’s Name</th>
<th>Group #</th>
<th>Policy #</th>
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<tbody>
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<td>[ ] Self [ ] Spouse [ ] Child</td>
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<td>[ ] Other</td>
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<tr>
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<th>Policy #</th>
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**IN CASE OF EMERGENCY**

<table>
<thead>
<tr>
<th>Name of local friend or relative to contact</th>
<th>Relationship to patient</th>
<th>Home Phone</th>
<th>Mobile Phone</th>
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</thead>
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</table>

**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
### 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.

<table>
<thead>
<tr>
<th>Home telephone #</th>
<th>(_______) __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile telephone #</td>
<td>(_______) __________________________</td>
</tr>
<tr>
<td>Work telephone #</td>
<td>(_______) __________________________</td>
</tr>
<tr>
<td>BEST number to reach you:</td>
<td>Home</td>
</tr>
</tbody>
</table>

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