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.

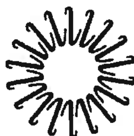
For more information about the Women's Medicine Collaborative, visit our website at WomensMedicine.org.

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

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

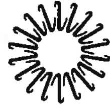
Definitions

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)

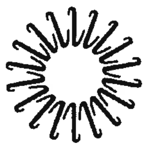
Park in the South parking lot.

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 ❑ 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

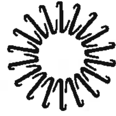
Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

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

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

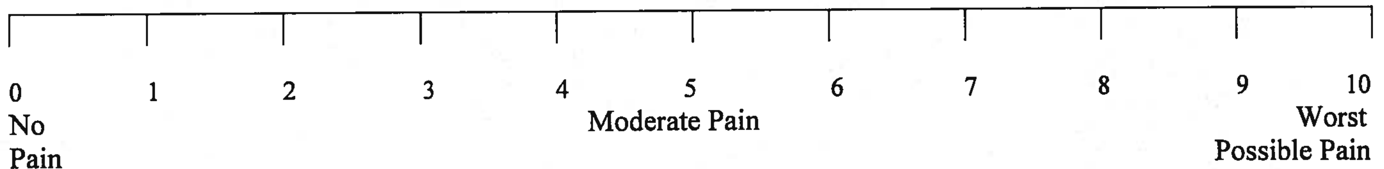
Hematologic/Lymphatic: ☐ easy bruising ☐ blood clot ☐ anemia ☐ swollen lymph glands

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)



0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

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

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**

Name ________________ Date of Birth ________________

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)** ________________
Lease 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: ________________

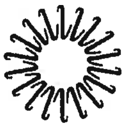
Do you feel safe at home at present? ☐ **No** ☐ **Yes**
Is anyone physically hurting or threatening you? ☐ **No** ☐ **Yes**
Is anyone hitting, kicking, or choking you? ☐ **No** ☐ **Yes**
Is anyone forcing you to do something sexually? ☐ **No** ☐ **Yes**
Do you have guns in your home? ☐ **No** ☐ **Yes**

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



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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?		

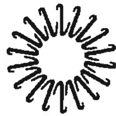
GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

	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
	Add the score for each column				
	Total Score (add your column scores) =				

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	

Spitzer RL[1], Kroenke K, Williams JB, Löwe B: A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.



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Patient Label

Patient Health Questionnare-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 <u>any</u> problems, how <u>difficult</u> 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.