

NEW ENGLAND WOMENCENTER

100 Brickhill Ave., Ste. 304, South Portland, Maine 04106
Tel: 207-761-4700 Fax: 207-761-4744

www.newenglandwomenscenter.com

Susan Doughty RN, MSN, WHNP-C

Dear New Patient,

Thank you for selecting New England Women Center for your health needs. Everyone here is committed to providing you with the best in women's health care. Founded in 1997, New England WomenCenter began with a focus on helping women who were dealing with the changes and transitions of menopause. Now, we serve women of all ages, from adolescence through postmenopause, with the same respectful approach.

New England WomenCenter has always been a place where women can:

- ❖ Find the best of gynecological health care
- ❖ Feel heard and respected
- ❖ Feel supported in making positive decisions
- ❖ Feel inspired to achieve health in every area of their lives

New Patient Form

Enclosed you will find a New Patient form that we ask you to complete before your initial visit with us. Please be sure to have this **completed** form with you at the time of your visit. Most people find it takes 20-30 minutes to complete the form.

Insurance and Referrals

Please bring your insurance information with you to your first visit. If you have insurance and your insurance company requires a referral, it is **your responsibility** to secure a referral from your primary care physician prior to your visit here.

Arrival

We respectfully request that you arrive at least fifteen minutes before your scheduled appointment so as to allow the administrative staff to process your information and answer any questions you may have.

Directions

From I-95 South or North, Maine Turnpike: Exit #46 and after toll booth turn right and right again at the light onto Western Ave. At the next traffic light turn left onto Jetport Plaza (the airport will be on your left and Staples will be on your right.). Take a right at the STOP sign onto Westbrook Street. Brickhill Ave. is about 1/4 mile on your left. After the left turn onto Brickhill, you will continue up the hill and the "Castle" will be on your left.

From I-295 North: Exit #3 (Westbrook St./Airport exit). At the end of the exit ramp turn right onto Westbrook St and right again at the next traffic light. You will soon see the sign for Brickhill Ave. which will be on your right. Continue up the hill and the "Castle" will be on your left.

From the Maine Mall area: Follow the Maine Mall Road to Jetport Plaza (Staples). Go straight thru the traffic light onto Jetport Plaza Rd. Take a right at the STOP sign onto Westbrook St..Brickhill Ave. is about 1/4 mile on your left. After the left turn, you will continue up the hill and the "Castle" will be on your left.

From Rte. 1 South: Follow Rt. 1 signs to 295 heading to Broadway. At end of ramp, turn right heading North on Broadway. Turn left at the next traffic light onto Westbrook St. Turn right at the next traffic light. You will soon see the sign for Brickhill Avenue on your right. Continue up the hill and the "Castle" will be on your left.

New England WomenCenter Policies

Please review this page and bring it to your first appointment to be signed at the office.

Fees

Fees for service vary according to the time we spend with you and the complexity of the problems we work on at your visit. When you make your appointment, we can give you an approximate charge based on the estimated time of the visit. Any outstanding balance will be due on or before your next scheduled visit, unless otherwise arranged with our office manager. If your insurance will not cover our services, we accept payment at the time of visit in cash, check, MasterCard or Visa. There is a \$25 fee for returned checks.

Insurance

We accept most major insurance plans. We encourage you to be well acquainted with the policy you have committed to. If you have a high deductible, we suggest you pay for each visits until you have met your deductible, in order to avoid paying a large accumulated fee at one time. You will be responsible for any unpaid balance not covered by your insurance.

Referrals

It is your responsibility to find out if your insurance requires a referral from your primary care provider (PCP) before your appointment with us. If you need a referral from your PCP, please obtain it before your first appointment with us. Please understand that **you will be responsible for all charges** that your insurance company does not cover if you fail to get a mandatory referral.

Additional Fees

Laboratories and consultants outside the New England WomenCenter will send their bills to you directly. These may include charges for mammograms, pap smear analysis, cultures, biopsies, blood work and similar services.

Cancellation Policy

We have a 24-hour cancellation policy. If you must cancel or reschedule an appointment, please notify us as soon as possible so that other women can be scheduled. If you cancel with less that 24 hours' notice, or do not show up for your visit, you will be charged \$50 for an annual exam and \$25 for an office visit. After hours, messages can be left on our voicemail.

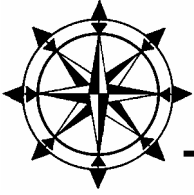
If you have any questions on the above policies or questions that are not answered here, please feel free to call us at 207-761-4700 before your appointment.

By my signature, I certify that I understand and agree to the above policies.

Client Signature

Witness

Date



NEW ENGLAND WOMENCENTER

260 Western Avenue, South Portland, Maine 04106
Tel. 207-761-4700 Fax: 207-761-4744

Susan Doughty, RN, MSN, WHNP-C
newenglandwomencenter.com

Initial History

PERSONAL INFORMATION

Date of first visit: _____

Name: _____

Date of birth: _____

Age: _____

TODAY'S VISIT

Who referred you to New England WomenCenter?

What would you like to discuss at your appointment today?

HEALTH CARE PROVIDERS

Who else do you see for health care? Please include complementary health providers as well.

	Name	Telephone number
Primary Care Provider:		
Therapist or Counselor:		
Pharmacy:		
Other:		

HEALTH SCREENING HISTORY

	Date	Result
Last mammogram		
Last bone density test		
Last cholesterol test		
Last colonoscopy		
Last Pap smear		

Have you ever had an abnormal Pap smear (circle)? Yes No

If so, when?

What was the abnormal result (if you know)?

MEDICAL HISTORY

Please check all that apply. For past problems, list your age(s) at the time of the problem.

	Present	Past (age)
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or angina	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>
Leaking urine or stool	<input type="checkbox"/>	<input type="checkbox"/>
Breast problems	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>
DES exposure	<input type="checkbox"/>	<input type="checkbox"/>

	Present	Past (age)
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss or growth	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>

List any other health problems here.

MAJOR ILLNESS, SURGERY AND INJURY HISTORY

List all operations, hospital stays, major injuries, and illnesses. (Do not include pregnancy).

Date	

MEDICATION HISTORY

List everything you take regularly (medications or supplements, by prescription or over-the-counter).

Medications	Directions	Date started	Prescriber

ALLERGY HISTORY

Are you allergic to any medications (circle)? Yes No If yes, please list below.

Medication or other substance	Reaction
Iodine or shellfish (circle): Yes No	
Latex (circle): Yes No	
Peanuts (circle): Yes No	

FAMILY HISTORY

Please list any family member who has ever had any of the following problems. For extended family, please indicate whether the person is on your mother's or father's side of the family.

Family member	Family member
High blood pressure:	Breast cancer (age):
Heart attack (age):	Colorectal cancer:
Stroke (age):	Ovarian cancer:
Blood problems:	Other cancer (type):
Blood clots:	Depression:
Bleeding tendency:	Other mental illness:
Osteoporosis:	Alzheimer's disease:
Hip fracture:	Alcohol abuse:
Diabetes:	Drug abuse:

List any other health problems in your family.

OBSTETRIC HISTORY

Have you had trouble with infertility or difficulty getting pregnant (circle)? Yes No
 How many adopted children do you have--if any? _____

Please list all pregnancies and any complications.

Date	Outcome (miscarriage, abortion, birth--vaginal or c-section)

GYNECOLOGIC HISTORY

How old were you when you first started your period? _____

Please complete this section if you have had periods in the last year.

Periods are: (circle) regular irregular
 How often do you have a period? _____ How many days does a typical period last? _____
 What was the first day of your last period? _____
 Please describe troubling symptoms before your period, if any. _____

Please complete this section if you have NOT had a period in the last year.

How old were you at your final period? _____
 Reason for periods stopping (circle): Natural Surgery Chemotherapy/Radiation
 Have you had a hysterectomy (circle)? Yes No
 If yes, what was the reason: _____
 Ovaries remaining (circle): Both Right Left None
 Have you ever taken hormone therapy for menopause (circle)? Yes No If yes, please list.
 Hormonal treatments tried: _____
 Approximate dates: _____

SEXUAL HISTORY

Have you **ever** been sexually active (circle)? Yes No If yes, have your partners been (circle): male / female / both
 About how many sexual partners have you had in your lifetime? _____

Are you **currently** sexually active (circle)? Yes No If yes, is/are your current partner(s) (circle): female / male / both
 Current number of sexual partners: _____

Please circle all birth control methods you have used (if any).

- | | | | |
|-----------------|--------------|---------------------|----------------|
| Calendar method | Condoms | Pill | IUD |
| Withdrawal | Diaphragm | Patch | Tubal ligation |
| | Cervical cap | Vaginal ring | Vasectomy |
| | Sponge | Depo Provera (shot) | |

Please check any STDs you have had (if any).

	<input type="checkbox"/>	Date		<input type="checkbox"/>	Date
Herpes	<input type="checkbox"/>		HPV-warts	<input type="checkbox"/>	
Chlamydia	<input type="checkbox"/>		HPV-abnormal pap	<input type="checkbox"/>	
Gonorrhea	<input type="checkbox"/>		Trichomonas	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>		HIV	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>		Other:		

Do you have concerns about your sex life (circle)? Yes No
 If yes, please indicate the problem here.

- Loss of interest in sexual activity (desire, initiative)
- Loss of arousal (tingling, lubrication, warmth)
- Loss of response (weak or absent orgasm)
- Pain with intercourse
- Other _____

HEALTH HABITS

Exercise

- I do not exercise regularly.
- I exercise _____ times per week for _____ minutes/hours at a time.

For exercise, I like to do the following: _____

Stress Management

The major stressors in my life are: _____

- To cope with stress, I do the following: _____
- I do not have a way to deal with stress. _____

Smoking

- I have never smoked.
- I smoke _____ cigarettes daily. I have been smoking for _____ years.
- I quit smoking _____ years ago. I smoked for _____ years.
- I am ready to try to quit smoking.
- I am not ready to try to quit smoking right now.

Alcohol

- I do not drink alcohol.
- I drink _____ servings of alcohol per week.
- I am in recovery and have been sober since _____

Other drugs

- I do not use recreational drugs.
- I use the following recreational drugs: _____
- I am in recovery and have been sober since _____

NUTRITION HISTORY

Describe any food allergies or intolerances. _____

Please list what you have eaten over the last 24 hours. _____

Thank you for taking the time to fill out this form. We look forward to reviewing it with you.

NEW ENGLAND WOMENCENTER

Notice of Privacy Practices Summary

The following is a summary of Privacy Practices at New England WomenCenter and how medical information about you may be used and disclosed and how you can go about getting access to this information. This notice is to comply with the Privacy Regulations in accordance with the Health Insurance Portability and Accountability Act of 1996.

As a patient of New England WomenCenter you have signed our *Consent to Use and Disclosure of Protected Health Information*. Based upon this consent, NEWC will use and disclose your medical information for the following reasons:

Treatment:

- To other healthcare professionals involved in your care
- Family members or friends directly involved in your care
- Other healthcare facilities involved in your care (hospitals, labs, nursing homes or home health services)
- To any staff members at NEWC who need the information to execute their job

Payment:

- For billing, claims management, and collection activities
- To insurance companies to determine eligibility
- For credit card processing
- To friends and family assisting you in the payment process

Healthcare Operations:

- Financial audits
- NEWC practice quality assessment and improvement activities
- Business planning and development
- General administrative activities (appointment reminder calls or e-mails to you, faxes to other health care providers, sign-in sheets, etc.)

In some circumstances, we may use or disclose your information without your consent or authorization if required by state or federal law to do so. For example:

- If you are incapacitated and require emergency treatment
- To public health authorities to prevent or control disease
- To comply with child or adult abuse or neglect law
- To health agencies for audits, inspections and investigations
- In response to a subpoena or other law enforcement purposes
- For medical or scientific research
- To comply with workers compensation laws

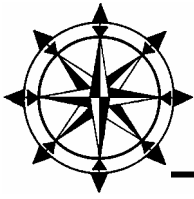
YOUR RIGHTS AS A PATIENT

The following is a summary of your rights as a patient of New England WomenCenter.

You have the right to:

- Request that we not use or disclose your information. We are not required to agree, but if we do agree, we will abide by your request except in a case of emergency.
- Request to view and or obtain a copy of your medical information. This request must be in writing and you may be charged for the cost of this service.
- Request that we convey your medical information in a specific manner.
- Request that we adjust your information but we will not remove or eliminate and information. This request must be made in writing stating the reasons for the adjustment.
- Request how and to whom we have released your information. Your request must be in writing.
- Request a copy of this notice for your personal files at any time.

If you have reason to believe that we are not complying with state and federal privacy laws, please state your complaint in writing to us at 260 Western Avenue, South Portland, ME 04106. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.



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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received and reviewed the *Notice of Privacy Practices*.

Name: _____

Birthdate: _____

Signature: _____

Date: _____