REMINDER

When you come to your first visit, please have the following:

-New Patient Packet
-Copay (cash or credit only)
-Insurance card
-Medication in the original bottle
-Any old or prior medical records or arrange to have them sent to us prior to your appointment.

Please arrive 10-15 minutes early fore your appointment.

Thank you.

Ria Medical, L.L.C.

Internal Medicine

(This information is necessary for our files and will be considered confidential)

Patient Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Marital Status: S - M - W - D Social Security#_____

Sex: M - F E-mail_____ Race_____

Referred by_____

Employed: Y - N Occupation_____Employer Phone_____

Emergency Contact Name_____ Phone_____

PRIMARY INSURANCE INFORMATION

Name of Insurance_____

Insurance ID#_____ Insurance Group#_____

Subscriber Name_____ Relation to Patient_____

Subscriber DOB _____ Subscriber SSN_____

Insurance Address_____

SECONDARY INSURANCE INFORMATION

Name of Insurance_____

Insurance ID#_____ Insurance Group#_____

Subscriber Name_____ Relation to Patient_____

Subscriber DOB _____ Subscriber SSN_____

Insurance Address_____

Past Medical History

Patient Name:_____ **Date of Birth:**_____

ALLERGIES

If you have no know allergies, please check the box at the right. □ No known allergies

1. Medication: _____ Reaction _____
2. Medication: _____ Reaction _____

MEDICAL HISTORY/ MAJOR ILLNESS (please check all that apply)

Hypertension	□Current	□Past	□N/A	Notes_____
Diabetes	□Current	□Past	□N/A	Notes_____
Cancer	□Current	□Past	□N/A	Notes_____
Stroke	□Current	□Past	□N/A	Notes_____
Heart Trouble	□Current	□Past	□N/A	Notes_____
Arthritis / Osteoporosis / Gout	□Current	□Past	□N/A	Notes_____
Seizure	□Current	□Past	□N/A	Notes_____
Bleeding Tendency	□Current	□Past	□N/A	Notes_____
Hereditary Disease	□Current	□Past	□N/A	Notes_____
Sexually Transmitted Disease	□Current	□Past	□N/A	Notes_____

SURGERIES (please list all major surgeries with estimated dates)

If you have not had any major surgeries, please check the box at the right. □ No surgeries to report

_____

_____

_____

_____

FAMILY HISTORY

Mother	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Father	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Brother	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Sister	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Child	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Grandmother (M)	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Grandmother (P)	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Grandfather (M)	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A
Grandfather (P)	□ Hypertension	□ Diabetes	□ Cancer	□ Other_____	□ N/A

SOCIAL HISTORY

Drink alcohol:	□ Currently	□ In the past	□ Never	How much and how often?_____
Use tobacco products:	□ Currently	□ In the past	□ Never	How much?_____
Substance abuse:	□ Currently	□ In the past	□ Never	What substance?_____
Caffeine:	□ Currently	□ In the past	□ Never	Number of cups per day?_____
Exercise:	□ Currently	□ In the past	□ Never	Type?_____
Sexual activity:	□ Yes	□ No		Number of partner in the last 5 years?_____

Seat Belt: □ Yes □ No Low fat die: □ Yes □ No

MEDICATIONS WITH DOSAGES (if you need more space, please use back of form)

If you are not currently taking any medications, please check the box at the right. □ No medications to report

_____

_____

_____

_____

PATIENT NAME:_____ DOB:_____

GENERAL SYMPTOMS		
Good general healthy lately	Y	N
Recent weight change	Y	N
Fever	Y	N
Fatigue	Y	N
Chills	Y	N
EYES		
Eye disease or injury	Y	N
Blurred or any drainage	Y	N
Glaucoma	Y	N
EARS		
Hearing loss or ringing	Y	N
Earache or any drainage	Y	N
Loss of balance	Y	N
NOSE		
Nose bleed	Y	N
Loss of smell	Y	N
Sinus pain	Y	N
THROAT		
Sore throat	Y	N
Bad breath	Y	N
Post nasal drip	Y	N
Bleeding gums	Y	N
Mouth sores	Y	N
CARDIOVASCULAR	Y	
Heart trouble		N
Chest pain or Angina	Y	N
Palpitations	Y	N
Shortness of breath with walking or lying flat	Y	N
Waking up at night with breathlessness	Y	N
Swelling of feet, ankles, or hands	Y	N
RESPIRATORY		
Asthma	Y	N
Chronic or frequent cough	Y	N
Phlegm (sputum)	Y	N
Spitting blood	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
GENITAL		
Sexual difficulty	Y	N
Pain in the genital area	Y	N
Lesions in genital area	Y	N
Sexually transmitted disease	Y	N
Discharge	Y	N
Pain in testicle	Y	N

URINARY		
Frequent urination	Y	N
Burning or Painful urination	Y	N
Blood in urine	Y	N
Flank pain	Y	N
Kidney stones	Y	N
Any change in force of stream when urinating	Y	N
Incontinence or dribbling	Y	N
ALLERGIC		
Drug allergy	Y	N
Food allergy	Y	N
Latex allergy	Y	N
MUSCULOSKELETAL	Y	
Rheumatic illnesses		N
Arthritis	Y	N
Osteoporosis	Y	N
Joint pain	Y	N
Joint stiffness	Y	N
Back pain	Y	N
Muscle or joint weakness	Y	N
SKIN		
Skin disease	Y	N
Rash	Y	N
Itching	Y	N
Change in color	Y	N
Change in the size or color of any moles	Y	N
NEUROLOGICAL	Y	
Headache		N
Light headedness	Y	N
Vertigo	Y	N
Loss of consciousness	Y	N
Convulsions or Seizures	Y	N
Tremors	Y	N
Paralysis or weakness	Y	N
Numbness or tingling sensation	Y	N
Stroke	Y	N
Head injury	Y	N
PSYCHIATRIC		
Memory loss	Y	N
Confusion	Y	N
Nervousness	Y	N
Depression	Y	N
Insomnia	Y	N

ENDOCRINE

Glandular or hormone problem	Y	N
Thyroid disease	Y	N
Diabetes	Y	N
Excessive thirst or urination	Y	N
Heat or cold intolerance	Y	N
Change in glove or hat size	Y	N

HEMETOLOGICAL

Bleeding or bruising tendency	Y	N
Anemia	Y	N
Clot in legs or lungs	Y	N
Enlarge lymph glands	Y	N

GASTROINESTIONAL

Abdominal pain	Y	N
Loss of appetite	Y	N
Change in bowel movement pattern	Y	N
Rectal bleeding or black stools	Y	N
Nausea or vomiting	Y	N
Blood or coffee ground like material in vomiting	Y	N

GYNECOLICIAL

Last menstrual period date _____

Last PAP smear date _____

Vaginal discharge	Y	N
Pain with period	Y	N
Irregular periods	Y	N

Pregnancy # _____ Miscarriage # _____

BREAST

Breast pain, lump, or nipple discharge	Y	N

Last mammogram date_____

Release of Information

Patient Name:_____ DOB:_____

Ria Medical is authorized to release protected health information about the above named patient to the entities names below. The purpose is to inform the patient or other in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/ entity on the left in the same section.
◯ Voice Mail	◯ Results of labs tests/ x -rays ◯ Other:_____
◯ Spouse (provide name & phone #) _____	◯ Financial ◯ Medical
◯ Parent (provide name & phone #) _____	◯ Financial ◯ Medical
◯ Other (provide name & phone #) _____	◯ Financial ◯ Medical
◯ Email communication (provide email address) _____	◯ Financial ◯ Medical

* In order to email communication to occur, please accept the disclosure below:

*Initial*____ I understand that if email is not sent in an encrypted manner, there is a risk it could be access inappropriately. I still elect to receive email communication.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health inform to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization my be subject to re-disclosure by the recipient and my no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

X_____ Date_____

Ria Medical, L.L.C.

Internal Medicine

105 Creekside Office Dr.
Wentzville, MO 63385
(phone) 636-639-6262
(fax) 636-639-1375

1343 NE Service Road East
Warrenton, MO 63383
(phone) 636-456-3340
(fax) 636-639-1375

Dr. Navin Choudhary, MD, ABIM - Dr. Pooja Patil, MD, ABIM - Dr Seema Iyer, MD, ABIM
Patty Rapplean, MSN, FNP-BC - Deborah Harrell, MSN, APRN, FNP-C

PATIENT NAME: _____
ADDRESS: _____
PHONE: _____
SSN: _____ **DATE OF BIRTH:** _____/_____/_____

I authorize the custodian of records of or others person/entity (specifically describe) to disclose/release the following information * (check all applicable):

_____ **All Records**
_____ **Laboratory / Pathology records.**
_____ **X-ray / radiology records**
_____ **Office visit notes**
_____ **Pharmacy / prescription records**
_____ **Other (describe specifically)** _____

- **Note: if these records contain any information from previous provider or information about HIV/AIS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease you are hereby authorizing disclosure of this information.**

I am requesting records from the following physician (use additional sheets if necessary):

PROVIDER NAME: _____
ADDRESS: _____
PHONE: _____
FAX: _____

This authorization shall expire on the following date : __/__/__ or one year from the date of signature.

-Re-Release
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment

-Right to Revoke
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present to the facility listed on the authorization. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will to apply to my insurance company when the law provides my insurer with right to contest a claim under my policy.

_____ **Date**_____
Signature of patient (or patient's personal representative)

_____
Printed name of patient or patient's personal representative)
i.e. parent, guardian, power of attorney for healthcare executor

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, Plan, and direct my treatment and follow-up among the multiple healthcare provider who my be involved in my treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations such as quality assessment and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the used and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health Care Operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print): _____ **Date:** _____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledge of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	**Initials**	**Reason**
_____	_____	_____

Medication Management Agreement

The Purpose of this agreement is to prevent misunderstandings about certain medicines you may take. This is to help you and the doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will treat me based on this agreement. I understand that if I break this agreement, my doctor will stop prescribing theses controlled medicines. If this is the case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

I will communicate fully with my doctor about the intensity and nature of my symptoms, the effect on my daily life, and how well the medicine is helping.

I will not use an illegal or controlled substance, including, but not limited to, marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my medication from loss or theft. Lost or stolen medicines WILL NOT BE REPLACED.

I agree that I will be seen for an office visit every 60 days. No refills will be available during evenings or weekends.

I agree to use _____ Pharmacy,

Located at _____.

Phone: _____ Date: _____

Signature: _____ Date:_____

RIA MEDICAL POLICY

1) In order to provide quality service to our patients, all cancelled appointments must be done 24 hours prior to scheduled appointment or it will be considered a NO CALL NO SHOW.

2) ALL NO CALL NO SHOW'S will be charged a $25 fee. Ultrasounds or other large testing will be at $50 fee. (This is a fee that is not chargeable to the insurance company.)

3) All returned checks will be charged a $30 fee. This is being levied as the bank charges penalty fees.

4) Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Copays and those who do not have insurance coverage are responsible to pay at the time of service and for your convenience we accept cash, check, MasterCard, Discover, Visa and money orders at our office.

5) The patient (or patient's guardian) is ultimately responsible to the payment for treatment and care. We are please to assist you by billing our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any changes incurred if the information provided is not correct or updated. You are ultimately responsible to know your coverage benefits.

6) Please allow 2 business days for medication refills. In most cases this process should not take longer than the end of the next business day. Therefore please consider this and try calling your pharmacy at least 5 days before your medications run out.

7) Co-pays are expected at time of visit

8) If you have a balance of $100 or more, a payment plan must be established prior to being seen.

9) Our office typically tries to contract you regarding any test results, but due to the HIPPA regulations, we are unable to leave a detailed message. It is the Patient's responsibility to obtain the results, so please call the office, should you fail to receive a call from us within 10 business days of routine blood or radiology testing. Our physician will take the necessary time to review patient's results in order to develop a treatment plan. The patients may be required to make a follow up appointment to discuss the results. (Please keep in mind, often times abnormal or complicated test results can not be communicated over the phone.)

10) Blood work is typically done through ClinLab or the hospital, if you prefer it to be done in an alternate facility/lab, please contact our friendly staff.

Name _____

Signature _____ Date: _____

Revised on 9/5/14