JAMES J DALLA RIVA, MD, FACOG
THOMAS M HULSEN, MD, FACOG
OBSTETRICS AND GYNECOLOGY
6812 STATE ROUTE 162, SUITE 301
MARYVILLE, IL 62062
PHONE: 618.288.5699 FAX: 618.288.5797

Dear Patient,

Thank you for choosing Dalla Riva and Hulsen Obstetrics and Gynecology for your health care needs. Enclosed you will find registration and history forms for you to fill out and bring with you to your scheduled appointment. These forms are for both new and established patients and we require them to be fully updated annually. Please fill out all of the forms in this packet completely to the best of your ability. It is recommended that you check with your insurance company and/or primary care physician prior to your visit to see if your insurance requires a referral. Please bring these completed forms, a physical copy of your insurance card and your copayment with you to your appointment. If you have any questions regarding your insurance coverage, benefits, or copayments, please contact the number on your insurance card prior to your appointment. **Please be advised that our office charges a $30.00 missed appointment fee for any appointments not cancelled in advance.**

Thank you,

Karen L. Copeland, CPC, RMC
Office Manager

James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
Obstetrics & Gynecology
6812 State Route 162, Suite 301
Maryville, Illinois 62062
618/288-5699*618/288-5797 (FAX)

GENERAL HISTORY

Name: Referred By: Date:

Age: Date of Birth: Marital Status:

Occupation: Occupation Concerns:

Covid Vaccinated: Yes / No Last Covid Booster: Current Gender Identity:

Blood Type: Rh Factor:

Health Habits - Caffeine: Tobacco: Alcohol: Recreational Drugs:

Date last period began: Cycle Length: Duration of bleeding:

Last pap smear: Normal/Abnormal: Last Mammogram:

Note if you have ever had any of the following problems:

Abnormal Pap Smear, Bleeding Between Periods, Breast Lumps, Extreme Menstrual Pain, Hot Flashes,
Nipple Discharge, Painful Intercourse, Vaginal Discharge, or any other problem not listed:

ALLERGIES - **DO NOT LEAVE BLANK**:

Chronic Illness:

Hospitalizations/Surgeries (list reason, type of surgery, and date):

PREGNANCY RECORD:

NO.	Month	Year	Name	Birth Weight	Sex	Weeks Pregnant	Hours in Labor	Type of Delivery & Complications

MEDICATIONS

Please list medications you are currently taking:

James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
Health History Continued

SYMPTOMS

Please check symptoms you currently have or have had in the past year.

General - Chills☐, Depression☐, Dizziness☐, Fainting☐, Fever☐, Forgetfulness☐, Headache☐, Loss of Sleep☐, Loss of Weight☐, Nervousness☐, Numbness☐, Sweats☐

Muscle/Joint/Bone (pain, weakness, numbness) - Arms☐, Back Feet☐, Hands☐, Hips☐, Legs☐, Neck☐, Shoulders☐

Genito-Urinary - Blood in Urine☐, Frequent Urination☐, Lack of Bladder Control☐, Painful Urination☐

Gastrointestinal - Poor Appetite☐, Bloating☐, Bowel Changes☐, Constipation☐, Diarrhea☐, Excessive Hunger☐, Excessive Thirst☐, Gas☐, Hemorrhoids☐, Indigestion☐, Nausea☐, Rectal Bleeding☐, Stomach Pain☐, Vomiting☐, Vomiting Blood☐

Cardiovascular - Chest Pain☐, High Blood Pressure☐, Irregular Heart Beat☐, Low Blood Pressure☐, Poor Circulation☐, Rapid Heart Beat☐, Swelling of Ankles☐, Varicose Veins☐

Eyes, Ears, Nose, Throat - Bleeding Gums☐, Difficulty Swallowing☐, Earache☐, Ear Discharge☐, Hay Fever☐, Hoarseness☐, Loss of Hearing☐, Nosebleeds☐, Persistent Cough☐, Ringing in Ears☐, Sinus Problem☐, Visual Changes☐

Skin - Easy Bruising☐, Hives, Itching☐, Changes in Moles☐, Rash Scars☐, Sores☐

CONDITIONS

Please check conditions you have or have had in the past.

AIDS☐, Alcoholism☐, Anemia☐, Anorexia☐, Appendicitis☐, Arthritis☐, Asthma☐, Bleeding Disorder☐, Breast Lump☐, Bronchitis, Bulimia☐, Cancer☐, Cataracts☐, Chemical Dependency☐, Chicken Pox☐, Diabetes☐, Emphysema☐, Epilepsy☐, Glaucoma☐, Goiter☐, Gonorrhea☐, Gout☐, Heart Disease☐, Hepatitis☐, Hernia☐, Herpes☐, High Cholesterol☐, HIV Positive☐, Kidney Disease☐, Liver Disease☐, Measles☐, Migraine Headaches☐, Miscarriage☐, Mononucleosis☐, Multiple Sclerosis☐, Mumps☐, Pacemaker☐, Pneumonia☐, Polio☐, Psychiatric Care☐, Rheumatic Fever☐, Scarlet Fever☐, Stroke☐, Suicide Attempt☐, Thyroid Problems☐, Tonsillitis☐, Tuberculosis☐, Typhoid Fever☐, Ulcers☐, Vaginal Infections☐, Venereal Disease☐

FAMILY HISTORY

Fill in the health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

Please check and list relationship to you if your blood relatives had any of the following:

Arthritis☐, Gout☐ ______________________ Asthma☐, Hay Fever☐ ______________________

Cancer☐ ______________________ Chemical Dependency ☐______________________

Diabetes☐ ______________________ Heart Disease, Strokes☐ ______________________

High Blood Pressure☐ ______________________ Kidney Disease☐ ______________________

Tuberculosis☐ ______________________ Other disease not listed☐ ______________________

Osteoporosis☐______________________ ______________________

JAMES J. DALLA RIVA, MD, FACOG * THOMAS M. HULSEN, MD, FACOG

PATIENT REGISTRATION INFORMATION

So we may accurately file claims to your insurance company, please fill in ALL blanks. Please present insurance cards to the Receptionist upon arrival.

Today's Date ______________________ **Referred By** ______________________________________

Primary Care Physician ____

Name ____

(First) (Middle) (Last)

Address ____

(Street) (City) (State) (Zip Code)

Home Phone Number _________________________ **Cell Phone Number** _______________________

Email Address ____

Marital Status: M☐ S☐ W☐ D☐ Date of Birth ________________________ **Age** ____________

Social Security # ___________________________ **Driver's License #** __________________________

Patient's Employer or School ____

Employer's Address _________________________________ **Phone Number** ___________________

Full Time/Part Time/Temporary _________________ **Occupation** ____________________________

GUARANTOR INFORMATION (Who insurance is through)

Spouse/Parent Name ____

Address ____

Phone Number ___________________ **Date of Birth** _______________ **SS#** __________________

Spouse/Parent Employer ____

Address ____ **Phone Number** _______________________

INSURANCE INFORMATION

Primary Insurance __________________________ **Subscriber Name** __________________________

ID Number _______________________________ **Group Number** ____________________________

Secondary Insurance __________________________ **Subscriber Name** ________________________

ID Number ________________________________ **Group Number** ___________________________

EMERGENCY CONTACT

Name ___________________________________ **Home Phone Number** _______________________

Address ________________________________ **Work/Cell Phone Number** ____________________

JAMES J. DALLA RIVA, MD, FACOG
THOMAS M. HULSEN, MD, FACOG

FINANCIAL POLICY

(Please read and sign where indicated)

I, the undersigned, have insurance coverage with ______________________________ and assign, directly to James J. Dalla Riva, MD all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronically. I hereby recognize and accept full responsibility for the timely payment of any balances remaining after such benefits have been paid, I have read and I understand this policy and the financial policy of this office.

____ ______________________

SIGNATURE **DATE**

MEDICARE PATIENTS

(Please read and sign where indicated)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to James J. Dalla Riva, MD / Thomas M. Hulsen, MD for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ______________________

SIGNATURE **DATE**

JAMES J. DALLA RIVA, MD, FACOG
THOMAS M. HULSEN, MD, FACOG
6812 State Route 162, Suite 301
Maryville, Illinois 62062
618/288-5699*618/288-5797 (FAX)

To Whom It May Concern:

I, ______________________________, give Dalla Riva and Hulsen, OB/GYN office personnel permission to release medical information to the following:

Person's Name   Phone #

____

____

____

____

This permission is in effect until I rescind same.

______________________________   ______________
Patient's Signature   Date

* I have received/declined a copy of the HIPAA informational packet.

______________________________   ______________
Patient's Signature   Date

* If we are unable to reach you, and you are ok with us leaving you a detailed voicemail, on your phone, please sign below.

______________________________   ______________
Patient's Signature   Date

PF - 1000 Notice of Privacy Practices / James J. Dalla Riva OB/GYN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical conditions being treated.

Health care operations. Your health information may be used as necessary to support the dayto-day activities and management of **DALLA RIVA OB/GYN**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate lawenforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Dalla Riva OB/GYN** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the
Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Dalla Riva OB/GYN may or may not agree to restrict the use or disclosure of your protected health information.

If **Dalla Riva OB/GYN** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to
Change Privacy Practices

Dalla Riva OB/GYN reserves the right to modify the privacy practices outlined in the notice.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of you medical condition that you may find to e of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund raising. Unless you request us not to, we may use your name and address to support our fund raising efforts.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

DALLA RIVA, OB/GYN Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your nest office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to you records by contacting **OUR RECEPTIONIST** or our **OFFICE MANAGER.**

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining you concerns to:

OFFICE MANAGER DALLA RIVA OB/GYN 6812 STATE ROUTE 162, SUITE 301 MARYVILLE, IL 62062

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filling a complaint.

Contact Person

The name of the person you can contact for further information concerning our privacy practices is our Office Manager, Karen L. Copeland, CPC

Effective Date

This Notice is effective on or after April 14, 2003

DALLA RIVA OBSTETRICS & GYNECOLOGY
James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG

PAYMENT POLICY

Thank you for choosing us as your OB/GYN providers. We are committed to providing you with quality and affordable health care. Please carefully read our payment policy. After reading this policy, please ask any questions you may have, and sign in the space provided. A copy of this policy will be provided to you upon request.

1. Self-pay. Please be aware that you will be responsible to the amount due at the time of service. Before seeing the provider, make sure you have the available funds with you to pay for the services provided. If you need an estimated cost, please ask to speak with our billing department prior to your visit. We accept cash, personal check, Visa, and MasterCard.

2. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we do participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we receive your up-to-date insurance card. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit unless other arrangements are made with our billing department.

5. Proof of insurance. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance.

6. Claim submission. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance pays your claim. Your insurance benefit is a contract between you and the insurance company.

7. Coverage changes. If your insurance company changes, please notify us before your next visit. If you fail to inform us of the change, you will be responsible for the bill.

8. Nonpayment. If your account is over 90 days past due, you may receive a letter stating you have 20 days to pay your balance. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. We may also

discharge you as a patient from this practice. If this is to occur, we will notify you by mail that you have 30 days to find an alternate medical provider. During that 30-day period, our providers will only be available to treat you on an emergency basis.

9. Missed Appointments. Our policy is to charge for missed appointments not canceled within a reasonable time frame. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping you scheduled appointments. Our practice is committed to providing the best treatment to our patients.

10. Our office only accepts Medicaid/Commercial Medicaid plans if they are the only insurance you have. If you have any other insurance, other than Medicaid, the other insurance is automatically primary. If you present us a Medicaid/Commercial Medicaid Card only, you are telling us, this is the only insurance you have. If Medicaid comes back and denies your services due to a different primary insurance, **YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT**.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

Signature ______________________________ Date ______________

Witness ______________________________

PLEASE READ THIS PAGE CAREFULLY TO UNDERSTAND WHY YOU MAY BE CHARGED DURING YOUR WELL WOMAN EXAM

James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
6812 State Route 162, Suite 301
Maryville, IL 62062
P: 618.288.5699
F: 618.288.5797

Dear Patient:

At Dalla Riva and Hulsen OB/GYN, we pride ourselves on offering our patients the most advanced preventative care available. As of August 2012, in accordance with the recommendations of the American College of Obstetrics and Gynecology and the American Society for Colposcopy and Cervical Pathology, we will be offering the following tests as part of our annual well woman visits:

Younger than 21
Pelvic Exam as Appropriate
Chlamydia/Gonorrhea Screening as Appropriate

Age 21 - 25
Pap Smear
Chlamydia/Gonorrhea Screening
If Pap is Abnormal - High Risk HPV Testing

Age 26 - 29
Pap Smear
If Pap is Abnormal - High Risk HPV Testing

Age 30 - 64
Pap Smear
High Risk HPV Testing
If Pap is Normal and HPV is Positive - Testing for HPV Types 16/18

HPV Testing in conjunction with a Pap Test for cervical cancer screening can show with nearly 100% certainty that you do not have cervical cancer. Here are a few things to know about cervical cancer screening:

1. Most women will have HPV at some point during their lives, but very few will develop cervical cancer
2. Cervical cancer develops if an HPV infection persists for many years
3. The Pap test looks for abnormal cell changes on the cervix that occur as a result of persistent high-risk HPV infection. The HPV test looks for HPV infection.
4. Women who test negatively for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
5. Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
6. Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies pay for HPV testing in women 30 and older. If yours does not, you may receive a bill from the Lab. If you do not want any of the testing listed above, please speak with your provider at your next well woman visit. Thank you and we look forward to seeing you soon.