

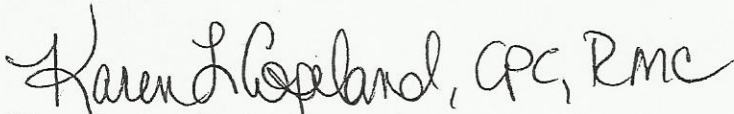
**JAMES J. DALLA RIVA, MD, FACOG  
THOMAS M. HULSEN, MD, FACOG  
MONICA E. MAJOR-HARRIS, APRN, FNP-BC  
OBSTETRICS & GYNECOLOGY  
6812 STATE ROUTE 162, SUITE 301  
MARYVILLE, ILLINOIS 62062  
618/288-5699 \* 618/288-5797 (FAX)**

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. Please fill all forms out to the best of your ability. Please check with your insurance company and/or primary care physician prior to your visit if your insurance requires a referral. Please bring your current insurance card along with your copayment to your visit. If you have any questions regarding your insurance coverage, benefits, or copayments, please contact the number on your insurance card prior to your visit.

Please be advised that our office has recently relocated. We are now located in Anderson Hospital Physicians Office Building #2, Suite 301. Our telephone number remains the same.

Thank you,



Karen L. Copeland, CFC, RMC  
Office Manager

072012

James J. Dalla Riva, MD, FACOG  
 Thomas M. Hulsen, MD, FACOG  
 Monica E. Major-Harris, APRN, FNP-BC  
 6812 State Route 162, Suite 301  
 Maryville, IL 62062  
 (618)288-5699 FAX (618)288-5797

GENERAL HISTORY

Name:		Referred By:		Date:	
Age:		Date of Birth:		Marital Status:	
Occupation:			Occupation Concerns:		
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:	

Circle 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 to Medications of Other Substances:
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:

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James J. Dalla Riva, MD, FACOG  
 Thomas M. Hulsen, MD, FACOG  
 Monica E. Major-Harris, APRN, FNP-BC  
 Health History Continued

**SYMPTOMS**

**Please circle 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** – Appetite Poor, Bloating, Bowl 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, Ear, Nose, Throat** – Bleeding Gums, Difficulty Swallowing, Earache, Ear Discharge, Hay Fever, Hoarseness, Loss of Hearing, Nosebleeds, Persistent Cough, Ringing in Ears, Sinus Problems, Visual Changes

**Skin** – Easy Bruising, Hives, Itching, Changes in Moles, Rash Scars, Sores

**CONDITIONS**

**Please circle conditions you have or have had in the past.**

AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, 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 circle 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 \_\_\_\_\_

Marital Status: M S W D Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers 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, M.D., F.A.C.O.G.*  
*THOMAS M. HULSEN, M.D., F.A.C.O.G.*

**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.

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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. Hulsén 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 the 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 noncovered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

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SIGNATURE

DATE

## DALLA RIVA OBSTETRICS & GYNECOLOGY

James J. Dalla Riva, M.D., F.A.C.O.G.

Thomas M. Hulsen, M.D., F.A.C.O.G.

### 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 pay 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 to 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 in 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 reasonable 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 or not 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.

(OVER)

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 timeframe. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. 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



James J. Dalla Riva, MD, FACOG  
Thomas M. Hulsen, MD, FACOG  
Monica E. Major-Harris, APRN, FNP-BC

6812 State Route 162, Suite 301  
Maryville, IL 62062  
p: 618.288.5699  
f: 618.288.5797

Dear Patient:

At DallaRiva and Hulsen OBGYN, 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 performing the following tests as part of our annual well woman visits:

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:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer
- Cervical cancer develops if an HPV infection persists for many years
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for HPV infection.
- Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- 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.
- 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.

[www.DallaRivaMedical.com](http://www.DallaRivaMedical.com)



## Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Date completed: \_\_\_\_\_

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or father's side**). Behind each statement, please list the relationship to you of the individual diagnosed. You and the following family members should be considered: mother, father, brother, sister, children, maternal/paternal aunts and uncles, nieces, nephews, first cousins, maternal/paternal grandparents and their **age at diagnosis**. This is a screening tool for the common features of hereditary cancer syndromes.

	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<b><u>BREAST AND OVARIAN CANCER</u></b>		
Y N - Breast cancer at any age	_____	_____
Y N - Ovarian cancer at any age	_____	_____
Y N - Breast cancer in both breasts or multiple primary breast cancers	_____	_____
Y N - Both breast & ovarian cancer	_____	_____
Y N - Pancreatic cancer with breast or ovarian cancer	_____	_____
Y N - Male breast cancer	_____	_____
Y N - 2 or more breast or ovarian cancers (in an individual or a family)	_____	_____
Y N - Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	_____	_____
Y N - Triple negative breast cancer (ER-, PR-, HER2-)	_____	_____
<b><u>COLON AND UTERINE CANCER</u></b>		
Y N - Uterine cancer before age 60	_____	_____
Y N - Colorectal cancer before age 60	_____	_____
Y N - Both uterine & colorectal cancer (in an individual or family)	_____	_____
Y N - 2 or more uterine or colorectal cancers (in an individual or a family)	_____	_____
Y N - Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)	_____	_____
Y N - 10 or more colon polyps found in a lifetime	_____	_____
Y N - Have you or a family member ever been tested for hereditary cancer syndromes?	_____	_____

<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing	<input type="checkbox"/> Patient offered genetic testing
<input type="checkbox"/> Information given to patient to review	<input type="checkbox"/> Accepted <input type="checkbox"/> Declined
<input type="checkbox"/> Follow up appointment scheduled Date: _____	<input type="checkbox"/> Not a Candidate for genetic testing

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

**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 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 condition being treated.

*Health care operations.* Your health information may be used as necessary to support the day-to-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 law-enforcement 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 your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service 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 next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

## **Requests to Inspect Protected Health Information**

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

## **Complaints**

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

**OFFICE MANAGER  
DALLA RIVA OB/GYN  
6810 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 filing 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**

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This Notice is effective on or after APRIL 14, 2003

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices of  
Dalla Riva Obstetrics and Gynecology and I have  
been provided an opportunity to review it.

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(Print Name)

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(Signature of patient)

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(Date)