Rajiv L. Yadava, D.O.
Shivi Yadava, D.O.
1050 Old Des Peres Road, Suite 100
St. Louis, MO 63131
Phone: 314-821-7577
Fax: 888-298-0691

Dear Patient,
Welcome and thank you for choosing Rajiv L. Yadava and/or Shivi Yadava as your physician. The following is a statement of our Financial Policy that we require you read and acknowledge with your signature at the bottom of this sheet. The undersigned acknowledges that part of the requested healthcare services from Rajiv L. Yadava, D.O. and Shivi Yadava, D.O. are considered unconventional by the mainstream medical establishment.

Appointments
Your appointment time is set aside for you and Dr. Yadava. Please understand we allow an hour for each patient visit and a missed appointment is lost time, which could have gone to another waiting patient. Without a 48-hour business day notice, patients who reschedule, cancel, or who forgot their appointments last minute will be charged for that visit. We will make an exception for bad weather and personal emergencies.

Payment Policy
All patients are required to complete and sign our patient information sheet before seeing Dr. Yadava. Payment is due before services are rendered for the office visit. We accept cash and all major credit cards. We do not accept checks.
If an account becomes delinquent, the account will be turned over to our legal department for collection. If an account requires legal action, any balance will be your responsibility. In the event legal collection becomes necessary you will personally be responsible for all collection fees, including court and attorney's fees and a 1.5% monthly interest of the unpaid balance. Please understand this is always the last option.

Patient or Patient's Guardian Signature

Date_____

PLEASE PRINT: **CHILD/MINOR FORM**

PATIENT NAME: _____ AGE: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____ SEX: _____

CITY: _____ STATE: _____ ZIP CODE: _____ STUDENT STATUS: FULL/ PARTTIME

HOME PHONE: (_____)_____ EMPLOYMENT STATUS: FULL/ PARTTIME

PERSONAL EMAIL ADDRESS: _____

REFERRED BY: _____ REASON FOR VISIT: _____

DATE OF INJURY: _____ IS INJURY RELATED TO? ( ) WORK ( ) AUTO ACCIDENT ( ) OTHER

IS THERE LEGAL ACTION PENDING? ( ) YES ( ) NO

ATTORNEY NAME, ADDRESS, PHONE: _____

RESPONSIBLE PARTY

FULL NAME: _____ AGE: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____ SEX: _____ MARITAL STATUS: S M W D

PERSONAL EMAIL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ STUDENT STATUS: FULL/ PARTTIME

HOME PHONE: (_____)_____ EMPLOYMENT STATUS: FULL/ PARTTIME

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____)_____ CELL/PAGER PHONE: (_____)_____

RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____

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Please Print:

MEDICAL HISTORY **TODAY'S DATE:** _____

PATIENT'S NAME: _____

ALLERGIES (MEDICATIONS/ ENVIRONMENTAL): _____

LIST THE FOLLOWING:

MEDICATIONS	DOSAGES	SURGICAL HISTORY	(DATES/AGE)	MEDICAL CONDITIONS	(DATES/AGE)

Please specify dental history (pulled teeth, root canals, fillings etc):

_____

_____

SOCIAL HISTORY:

SMOKE: Y /N - if applicable please specify number of years, packs per day, quit dates, and if chewing

ALCOHOL: Y / N - if applicable please specify average number of drinks per week

CAFFEINE: Y / N - if applicable please specify average number of drinks per week

OCCUPATION: _____

Please explain your personal birth history if able: (ex. Surgical delivery methods, biological mother's health during pregnancy etc)

FAMILY HISTORY: PLEASE LIST MEDICAL CONDITIONS.
(IF DECEASED, WHAT WAS YOUR AGE WHEN THAT OCCURRED.)

MOTHER:

_____

FATHER:

_____

CHILDREN:

_____

BROTHER/SISTER:

GRANDPARENTS:

_____

IF FEMALE PATIENT: MENSTRUATION STARTED AT AGE: _____
FIRST DAY OF LAST PERIOD: _____
HOW OFTEN AND HOW LONG ARE MENSTRUAL CYCLES: _____
PAIN WITH MENSES: _____

RAJIV L. YADAVA, D.O.
SHIVI YADAVA, D.O.

INITIAL OFFICE VISIT **DATE: _____**
(Patient to Complete)

PATIENT NAME: _____ AGE: _____

PRIMARY CARE PHYSICIAN:_____

REFFERED BY:_____

SUBJECTIVE:
Main Concern (chief complaint):_____

Onset/duration:_____ Location:_____

Description/quality:_____ Severity score: 0 1 2 3 4 5 6 7 8 9 10
(0-least 10-worst)

Gets better with:_____ Gets worse with:_____

History:_____

MEDICATIONS/ VITAMINS-SUPPLEMENTS/ ALLERGIES/ PAST HISTORY: MEDICAL/ SURGICAL/ FAMILY & SOCIAL : (SEE FORM ATTACHED)

Review of Symptoms: ***circle any chronic or current symptoms, the remainder is negative***
Fatigue, weight loss, insomnia/ blurry vision, change in vision, poor vision/ ear pain, hearing loss/ throat pain, hoarseness, sinus pain, nasal congestion, cough/ shortness of breath, wheezing, chest pain, palpitations/ nausea, vomiting, diarrhea, constipation, bloating, abdominal pain, acid reflux/ urinary burning, incontinence/ joint pain, muscle pain/ headache, numbness, tingling, dizziness, muscle weakness, bruising, bleeding, hair loss, dry skin, intolerance to heat /cold, hot flashes, depression, anxiety, allergy to drug/environment/food.

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MEDICAL RELEASE AUTHORIZATION

THIS IS TO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION
AND/OR X-RAYS TO THE ABOVE PHYSICIAN'S OFFICE

PATIENT'S NAME: _____

DATE OF BIRTH: _____

RESPONSIBLE PARTY: _____

FROM: _____

_____

DATE(S) OF SERVICE: _____

_____

REGARDING: _____

_____

_____

_____

_____ _____
Patient or Responsible Party's Signature Date

PRIVACY NOTICE SUMMARY

This is a ***summary*** of our Privacy Notice regarding patients' protected health information. If you wish to read the notice in its entirety, please ask the office manager for a copy.

Who Will Follow This Notice

This notice describes our policy regarding the use of your medical information. All physicians, employees, staff and other authorized personnel who may need access to your medical information are bound by this policy.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. This notice describes the ways we may use and disclose medical information about you. We also describe your rights, as well as certain obligations we have, regarding the use and disclosure of medical information.

We are required by law to 1) keep medical information that identifies you private: 2) give you notice of our legal duties and privacy practices with respect to medical information about you; and 3) follow the terms of the notice that is currently in effect.

How We May use and Disclose Medical Information About You

There are different ways that, by law, we may use and disclose medical information. Here are several examples.

- For treatment.
- For payment.
- For health care purposes.
- For appointment reminders.
- For notifying you of treatment alternatives.
- For health-related benefits and services.
- For individuals involved in your care or payment for your care.
- For research (under certain circumstances).
- As required by law.
- To avert a serious threat to health or safety.
- To military officials if you are in the military or are a veteran.
- For workers' compensation claims.
- For health oversight activities.
- For lawsuits and disputes.
- For law enforcement.
- To Coroners, Medical Examiners and Funeral Directors.
- For protective services for the President, National Security and Intelligence Activities.
- To prison officials of patients who are inmates.

There is a description of each in the full version of this notice.

Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- Right to inspect and copy.
- Right to amend.
- Right to an accounting of disclosures.
- Right to request restrictions.
- Right to request confidential communications.
- Right to a paper copy of this notice both in summary and in complete version.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our medical practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our medical practice, please contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Our Privacy Officer:

NAME: **Alpna Yadava**
TITLE: **Office Manager**
OFFICE OF: **Rajiv L. Yadava, D.O. and Shivi Yadava, D.O.**
ADDRESS: **1050 Old Des Peres Rd., St. Louis, MO 63131**
PHONE: **314-821-7577**

Patient Acknowledgement (please check all that apply):

☐ I have read this summary but do not wish to read the full version.

☐ I have read this summary and the full version.

☐ I have requested and received a copy of the summary.

☐ I have requested and received a copy of the full version.

Patient Signature:

_____

Patient Printed Name:

_____ Date _____

For Office Use Only:

Confirmed/Declined ***Initial:*** _____ ***Date:*** _____