RYAN INTERNAL MEDICINE

1350 RIM DR.
FLAGSTAFF, AZ 86001
(928)213-5881PH (928)226-0317FX
Office Hours: Mon-Thurs 8am-5pm Closed for Lunch 12pm-1pm
Friday: 8am-12pm

Welcome to Ryan Internal Medicine. We specialize in primary care for adults: providing wellness physicals, preventive medicine including diagnostic cardiology and treating chronic diseases like diabetes and asthma. Additionally we strive to take care of the whole patient and will coordinate the care you receive from other specialists.
Additionally, Ryan Internal Medicine charges an annual membership fee of $100 to all its' patients. This is a fee not covered by insurances. This fee allows us to go above and beyond for our patients to provide safe, confidential, legible care including electronic prescribing, same day or next day urgent appointments, 24hr provider on call and web access. Using Patient Portal you can view records, balances, and lab results as well email requests for appointments, questions, etc.

FIRST VISIT:

- ✓ Bring all paperwork received by Ryan Internal Medicine
- ✓ Bring all medication bottles
- ✓ Bring all insurance cards
- ✓ Bring past medical records

Cancellations & No Shows:
Please notify our office 24hr in advance of a cancellation. This will enable us to fill the spot with another patient. Failure to notify our office may result in being charged for the time reserved.
New patients who fail to keep their scheduled appointment, and who fail to notify the office, may not be permitted to schedule an appointment in the future.

Prescription Refills:
Please contact your pharmacy when you are in need of a refill. The pharmacy will notify us of your request. Please anticipate your need for medicine. Up to a 48hr turnaround is necessary to process refills. Requests for written prescriptions require up to 72hr turnaround. We will notify you when their ready for pick up.

Test Results:
All tests are reviewed by your physician. You will then receive a letter indicating the results. If your tests are abnormal, you may be asked to set up an appointment to go over them with your physician. If you do not hear from us via letter or phone please feel free to call to check the status of your results.

Medical Records Request:
Your medical records are kept in the strictest of confidence. The physical records belong to the practice. You are entitled to know what's in your records and may obtain copies after completing and signing a "Records Request Form." Please allow 10 working days to process your request. There may be a fee to provide copies to you or to outside parties for non-medical care purposes.

Additional Fees for Physicians Time:
There Will be a $50.00 fee for physicians to fill out medical forms such as FMLA, Disability, ect..

Payments:
Payment and Co-pays are expected at the time of service. We Accept cash, Visa, MasterCard, Discover, American Express and checks.

Insurance:
It is ultimately the patient's responsibility to know what is, or what is not covered by your insurance company. If you have questions about coverage, please contact your insurance company prior to scheduling appointments or procedures.
We are contracted with the following insurance companies:

- Blue Cross & Blue Shield
- Champus/Tricare
- Medicare & Medicare Replacement Plans
- Arizona Foundation for Medical Care Network
- United Healthcare
- Healthnet
- Humana

We do not accept Workman's Compensation.

Emergencies:
FOR ALL MEDICAL EMERGANCYS PLEASE CALL 911. If you call our office outside regular office hours and wish to speak with the provider on call please call 213-5579.

Directions to our Office:
Turn onto N Humphreys St. (Rodeway Inn Downtown is on the corner)
Turn left onto N Fort Valley Rd/US-180. (N Fort Valley Rd is just past W Sullivan Ave)
Take the 1st right onto W Forest Ave. (Just past W Havasupai Rd, heading up hill)
Take the 1st right onto N Rim Dr. (Half way up the hill)
1350 Rim Dr. is on the Left hand side.

Ryan Internal Medicine
1350 Rim Dr.
Flagstaff, AZ 86001

Please review the information below. If any item is incorrect
Please cross it out and write in the correct information and sign at the bottom.

Patient Name:_____

Mailing Address:_____

_____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

Social Security Number: _____

Marital Status: _____

Email Address: _____

Race:_____

Ethnicity:_____

Language:_____

Insurance Information

Primary Insurance:_____

Subscriber Name:_____ Date of Birth: _____

Subscriber ID:_____ Group Number: _____

Secondary Insurance: _____

Subscriber Name:_____ Date of Birth: _____

Subscriber 1D:_____ Group Number:_____

Pharmacy Name: _____ Pharmacy Number: _____

Insurance Signature On File

This authorization allows the release of any medical information to my insurance carrier when necessary to process my claims. I authorize payments under my insurance programs to be made directly to Ryan Internal Medicine, PC. I understand that I am financially responsible for all charges weather or not they are covered by insurance, including collections fees.

Responsible Party

Signature:_____Date:_____

Notice of Privacy Practices—Ryan Internal Medicine

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation; created as a result of the Health Insurance Portability and Accountability Act of l996(HIPAA).

Our commitment to your privacy

Ryan Internal Medicine PC (RIM) is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. For lawsuits and similar proceedings in response to a court **or** administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person **or** organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Medical Records Department at the address on the front of this notice.
4. You have the right to request that we consider amending your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Medical Records Department at the address on the front of this notice. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our Medical Records Department, at the address on the front of this notice.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Practice Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our facility.

If you have any questions regarding this notice or our health information privacy policies, please contact the RIM Front Office Supervisor.

I hereby acknowledge that I have been presented with a copy of the Ryan Internal Medicine Notice of Privacy Practice.

SIGNATURE of Patient: *DATE:*

Source: Advocacy Resource Center of the American Medical Association. October 1999.

Ryan Internal Medicine
Health History
(Confidential)

Name _____ Today's Date _____

Age _____ Birth date _____ Date of Last Exam _____

What is your reason for visit? _____

Previous Provider? _____

Previous Hospitalizations, Surgeries, Illnesses		
Year	**Hospital**	**Reason**

Medications: list prescription and non-prescription medications that you are taking	**Allergies: to medications or substances and type of reaction**
	Past Immunizations: type and date

Family History						
Relation	**Age**	**State of Health**	**Age of Death**	**Check if your blood relatives have had any of the following**		
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

(**OVER**)

Social History: Please Describe	
Caffeine:	
Tobacco: Current User: Y/ N? If yes, how much and how long?	Former User: Y/ N?
Drugs:	
Alcohol:	
Exercise:	
Work:	
Residence: Alone or With Family?	
Sexually active:	

- ✓ **Symptoms**: Check symptoms you are currently having or have had in the past:

General
__ Chills
__ Depression
__ Fever
__ Headache
__ Loss of Sleep
__ Numbness
__ Sweats
Other_____

Eyes, Ears, Nose, Throat
__ Difficulty swallowing
__ Double vision
__ Earache
__ Hay Fever
__ Hoarseness
__ Loss of Hearing
__ Ringing in Ears
__ Sinus Problems
Other_____

Pulmonary
__ Shortness of breath
__ Cough
__ Sputum Production
__ Shortness of Breath on Exertion
Other_____

Cardiovascular
__ Chest Pain
__ Shortness of Breath at Night
__ History of Heart Attack
__ Fainting/Dizzy Spells
__ Palpitations
Other_____

Gastrointestinal
__ Indigestion
__ Nausea
__ Vomiting
__ Change in Bowel Habits
__ Constipation
__ Diarrhea
Other_____

Genitourinary
__ Blood in Urine
__ Frequent Urination
__ Lack of Bladder Control
__Men-Lump(s) in Testicles
Other_____

CNS
__ Seizures
__ Stroke
__ Fainting
__ Weakness
__ Numbness
Other_____

Skin
__ Change in mole
__ Rash
__ History of Skin Cancer
Other_____

Muscle/Joint/Bone Pain, Weakness, Numbness
__ Arms
__ Back
__ Feet
__ Hands
__ Hips
__ Legs
__ Neck
__ Shoulder

Women Only
__ Abnormal Pap
__ Bleeding between periods
__ Breast Lump
__ Hot Flashes
__ Nipple Discharge
__ Painful Intercourse
__ Vaginal Discharge
Other_____

Date of menstrual Period _____

Date of last Pap Smear_____

Have you had a Mammogram? ____
Date: _____
Are you pregnant? ____
Number of children? ____

Comments: