

Nader Rahmanian, MD LLC

INTERNAL MEDICINE / GERIATRIC MEDICINE

Amanda Koch, PAC
Codi Logsdon, CRNP

1416 PENN AVENUE
WYOMISSING, PA 19610
TELEPHONE 610-376-3936
www.yourprimarymd.com

Welcome to Our Practice

Founded in 1990 in Berks County as a solo practice, Dr. Nader Rahmanian has been providing one-on-one care in a warm, home-like environment. He specializes in the care of adults, including but not limited to the geriatric population, and was one of the first board-certified geriatricians in the county.

Dr. Rahmanian has practiced a coordinated, comprehensive care model—similar to today’s “medical home” concept—since the beginning of his career. Rather than fragmented care among various specialists, he provides consistent, full-spectrum care as a single physician overseeing and coordinating your medical needs.

Our practice treats every patient like family. Our compassionate, professional staff is dedicated to delivering the highest level of personalized care. As a physician-owned practice, we are not driven by corporate policies or profit margins. This independence allows us to remain patient-focused and uphold our values of attentive, individualized care.

Dr. Rahmanian briefly experienced the corporate medical model but found it limiting in his ability to fully prioritize patient needs. He returned to private practice, where he can best serve patients with the traditional, relationship-based care he values most.

Our office environment reflects this philosophy. There are no glass barriers separating patients from staff—you’ll find a cozy, country-inspired atmosphere personally decorated by Dr. Rahmanian, with handmade touches from his wife. It’s all part of creating a welcoming, comfortable space that feels like home.

New Patients Are Welcome!

We are excited to welcome you to our practice. Please review the following important information for your first visit:

- **Arrival:** Please arrive 10 minutes early.
- **What to Bring:** A photo ID, insurance card, and co-pay.
- **Fragrance-Free Policy:** Please refrain from wearing cologne, perfume, or scented lotion, as Dr. Rahmanian is allergic to many fragrances.
- **Parking:** Handicap-accessible parking is available behind the building.
- **Appointment Duration:** Your first appointment will be approximately 60 minutes.

Cancellation & No-Show Policy

- If you need to cancel, please give at least **2 business days’ notice**.
 - If you do not show up or cancel without proper notice and without a true emergency, a **\$100 no-show fee** will apply before you can reschedule.
 - A **second no-show** may result in dismissal from the practice.
 - Established patients must provide **at least 24 hours’ notice** for cancellations, or a **\$25 fee** will apply (unless there’s proof of emergency).
-

Office Policies & Procedures

- **Lab Slips/Prescriptions:** We do not mail lab or X-ray slips or prescriptions unless you provide a **stamped, self-addressed envelope**. You may also pick them up in person or leave extras in your chart for future use.
- **Forms and Letters:** There is a charge for all forms and letters, as they are not reimbursed by insurance. Medical record copies are subject to state-mandated fees, which will be included with your bill.
- **Voicemail System:** If we cannot answer the phone, our voicemail will activate. Messages are checked frequently. **Do not leave emergency messages**—call 911 for emergencies.
- **Prescription Refills:** Please allow **48 hours** for refills. Check your medications regularly and call during business hours **before running out**. We are not responsible for delays due to late refill requests.
- **Illness Visits:** We aim to limit handling of illness over the phone. Patients will usually be asked to come in to be evaluated by a nurse or provider, with consultation from Dr. Rahmanian. Co-pays and insurance billing will apply. Work excuses will not be issued for days prior to notifying us, unless it was over a weekend. No excuse will be given if Dr. Rahmanian feels the patient is fit for work.

HMO Patients

Per HMO rules, **referrals to specialists must be requested before making appointments**. Dr. Rahmanian will determine if the referral is appropriate. **No exceptions**. Some HMO plans allow gynecology visits without prior approval. Please request referrals **at least 7 days before your specialist appointment**.

After-Hours Calls

If you need to speak with Dr. Rahmanian outside regular hours, please make sure **your caller ID is turned off**. For privacy reasons, he will not return calls from his home unless his number is blocked. If your phone does not accept blocked calls, you will not receive a call back.

We are honored that you have chosen to join our practice and look forward to providing your care. Please feel free to contact us with any questions.

Sincerely,

N. Rahmanian, M.D. & Staff

Nader Rahmanian, MD LLC

N. Rahmanian, MD

*Amanda Koch, PAC
Codi Logsdon, CRNP*

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COMPLETE MEDICAL HISTORY FORM

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

Phone Home: _____ **Cell:** _____ **Email:** _____

I. PAST MEDICAL HISTORY:

A. In the past, have you been diagnosed as having any of the following conditions? Check and date:

<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Hardening of the arteries		<input type="checkbox"/> Phlebitis (blood clots)	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Migraine headaches	
<input type="checkbox"/> Stroke or "TIA"		<input type="checkbox"/> Cluster headaches	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Tension headaches	
<input type="checkbox"/> Angina		<input type="checkbox"/> Congestive heart failure	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Menieres Disease	
<input type="checkbox"/> Nasal polyps		<input type="checkbox"/> Allergic rhinitis	
<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Gum disease	
<input type="checkbox"/> Cervical (neck) strain		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lupus		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Chronic bronchitis	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Fibrocystic breast disease		<input type="checkbox"/> Galactorrhea(breast discharge)	
<input type="checkbox"/> Hyperthyroidism (over-active thyroid)		<input type="checkbox"/> Hypothyroidism (low thyroid)	
<input type="checkbox"/> Pernicious anemia		<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Peptic ulcer (gastric or duodenal)		<input type="checkbox"/> Iron deficiency anemia	
<input type="checkbox"/> Gastritis/Esophagitis		<input type="checkbox"/> Giardia or other parasite	
<input type="checkbox"/> Intestinal polyps		<input type="checkbox"/> Malabsorption	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Diverticulitis	
<input type="checkbox"/> Irritable bowel (spastic colon)		<input type="checkbox"/> Chronic Fatigue syndrome	
<input type="checkbox"/> Reflux or GERD		<input type="checkbox"/> Enlarged prostate	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Crohn's colitis	
<input type="checkbox"/> Ulcerative colitis		<input type="checkbox"/> Prostatitis (prostate infection)	
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Pelvic inflammatory disease	
<input type="checkbox"/> Epididymitis		<input type="checkbox"/> Uterine Fibroids	
<input type="checkbox"/> Dysmenorrhea		<input type="checkbox"/> Cystitis(bladder infection)	
<input type="checkbox"/> Vaginitis		<input type="checkbox"/> Hepatitis A, B or C	
<input type="checkbox"/> Pyelonephritis (kidney infection)		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Kidney Stone		<input type="checkbox"/> Gallstones	
<input type="checkbox"/> Hypoglycemia		<input type="checkbox"/> PMS or PMDD	
<input type="checkbox"/> Bulimia or Anorexia		<input type="checkbox"/> Depression	

<input type="checkbox"/> Any kind of Cancer		<input type="checkbox"/> Multiple sclerosis	
What kind of cancer?			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Osteopenia		<input type="checkbox"/> Neurologic disease	
<input type="checkbox"/> Abnormal x-ray findings:		<input type="checkbox"/> Panic attacks	
Describe		<input type="checkbox"/> High cholesterol or Triglycerides	
<input type="checkbox"/> Abnormal pap smear		<input type="checkbox"/> Sexual dysfunction	

List any other problems not mentioned above:

B. Surgeries:

T & A (tonsils) Date: _____ Hysterectomy Date: _____

Appendectomy Date: _____ Ovaries removed? Yes No (circle)

Cholecystectomy (gallbladder) Date: _____

Other surgeries and dates: _____

Biopsies done: what kind and dates: _____

C. Hospitalizations: (other than for surgeries)

Date: _____ Where: _____ Reason? _____

D. Injuries/Fractures (type, date and how injured):

E. Present Medications (prescription and over-the-counter):

Name Dose #Taken daily Reason

F. Herbs and Supplements: _____

NAME: _____

G. Allergies: _____ or No known drug allergies

Medications: _____ What reaction: _____

Other Allergies to Substances, Foods, etc:

H. Immunizations: Check Childhood Shots Given:

DPT _____ Mumps _____ Measles _____ Rubella _____ Polio _____ Smallpox _____

Tetanus Booster Date: _____

Pneumovax (pneumonia vaccine) Date: _____

Influenza (date of last shot) Date: _____

Hepatitis B (series of 3 shots) Date: _____

Covid 19 Date 1st: _____ Date 2nd: _____

Other Date: _____

II. FAMILY HISTORY

Mother: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems she has had:

Father: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems he has had:

Brother (s) Ages and any medical problems he/they have had: _____

Sister (s) Ages and any medical problems she/they have had: _____

Any other blood relatives with:

Relationship	Relationship
Diabetes _____	High blood pressure _____
Heart attack _____	Breast cancer _____
Stroke _____	Colon cancer _____
Tuberculosis _____	High cholesterol _____
Dementia _____	Melanoma (skin cancer) _____
Prostate cancer _____	Ovarian cancer _____
Other major Illness _____	Other cancers _____
Mental Illness _____	

NAME : _____

III. SOCIAL HISTORY

A. Marital Status:

Single Married Divorced

B. Have you ever been pregnant? Yes No N/A

If yes, how many pregnancies? _____ How many births / children? _____

C. Smoker (currently) ex-smoker nonsmoker chewing tobacco

If a smoker, number of packs (pipes, cigars) per day: _____

How long have you smoked? _____ If ex-smoker, when did you quit? _____

D. Alcohol intake:

What do you usually drink? _____ How much? _____ How often? _____

Do not drink alcohol

E. Exercise:

Do you exercise regularly? _____ What activity? _____

How often? _____ How long is each session? _____

F. Diet -Check any foods you **avoid** in your diet:

salt sugar fats (oils) red meat eggs poultry wheat caffeine

other _____

G. Usual number of meals per day: _____ Number of times per week you eat "fast foods" _____

H. Travel: Have you recently traveled outside the U.S.? _____

Where did you go? _____

I. Work :

Current Occupation: _____

Have you had any work related illnesses or injuries? _____

Injury/Illness _____ while employed as:

Do you have a history of exposure to toxic chemicals or substances? Yes No

What _____ Where _____ When _____

J. Do you have a living will? () Yes () No ***PLEASE BRING COPIES TO PUT IN YOUR CHART***

Do you have a Power of Attorney? () Yes () No

If yes, who is your POA? _____

NAME: _____

IV. Presently or in the recent past, have you had any of the following symptoms:

<input type="checkbox"/> Recurrent headaches		<input type="checkbox"/> Weight loss # of pounds lost	
<input type="checkbox"/> Fever (unexplained)		<input type="checkbox"/> Chills	
<input type="checkbox"/> Generalized fatigue		<input type="checkbox"/> Generalized weakness	
<input type="checkbox"/> Double vision		<input type="checkbox"/> Ringing in ears	
<input type="checkbox"/> Recurrent sinus infection		<input type="checkbox"/> Recurrent sore throats	
<input type="checkbox"/> Hoarseness		<input type="checkbox"/> Neck stiffness	
<input type="checkbox"/> Coughing up blood		<input type="checkbox"/> Chronic cough	
<input type="checkbox"/> Chest pressure or tightness on exertion		<input type="checkbox"/> Chest pressure of tightness at rest	
<input type="checkbox"/> Feeling dizzy or off-balance		<input type="checkbox"/> Pain in legs while walking	
<input type="checkbox"/> Change in appetite		<input type="checkbox"/> Abdominal burning pain	
<input type="checkbox"/> Nausea		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Change in bowel habits		<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Painful urination		<input type="checkbox"/> Change in urinary habits	
<input type="checkbox"/> Breast Pain		<input type="checkbox"/> Weight gain # of pounds gained	
<input type="checkbox"/> Night Sweats		<input type="checkbox"/> Generalized body aches	
<input type="checkbox"/> Change in vision		<input type="checkbox"/> Change in hearing	
<input type="checkbox"/> Frequent nosebleeds		<input type="checkbox"/> Recurrent gum or tooth infections	
<input type="checkbox"/> Constant sinus drainage		<input type="checkbox"/> Trouble swallowing	
<input type="checkbox"/> Swollen glands		<input type="checkbox"/> Shortness of breath on exertion	
<input type="checkbox"/> Shortness of breath while laying down		<input type="checkbox"/> Coughing up phlegm in the morning	
<input type="checkbox"/> Feeling faint or almost passing out		<input type="checkbox"/> Swollen ankles or feet	
<input type="checkbox"/> Heartburn or indigestion		<input type="checkbox"/> Abdominal cramping pain	
<input type="checkbox"/> Vomiting		<input type="checkbox"/> Constipation	
<input type="checkbox"/> Blood in or on stool		<input type="checkbox"/> Frequent or urgent urination	
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Vaginal discharge or odor	
<input type="checkbox"/> Change in menstrual periods		<input type="checkbox"/> Change in sexual desire	
<input type="checkbox"/> Breast lump		<input type="checkbox"/> Nipple discharge	
<input type="checkbox"/> Testicular pain		<input type="checkbox"/> Skin rash	
<input type="checkbox"/> Easy bruising or bleeding		<input type="checkbox"/> Changes in hair	
<input type="checkbox"/> Trouble sleeping		<input type="checkbox"/> Depression	
<input type="checkbox"/> Muscle weakness or pain		<input type="checkbox"/> Tingling in hands or feet	
<input type="checkbox"/> Joint swelling		<input type="checkbox"/> Testicular swelling	
<input type="checkbox"/> Changes in skin or moles		<input type="checkbox"/> Lumps in neck, underarms or groin	
<input type="checkbox"/> Sensation of being too hot or too cold		<input type="checkbox"/> Nervousness, panic	
<input type="checkbox"/> Mood swings		<input type="checkbox"/> Numbness	
<input type="checkbox"/> Joint pains		<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Head injury and loss of consciousness		<input type="checkbox"/> Memory loss	

List any other problems not mentioned above:

NAME: _____

V. HEALTH MAINTENANCE

- A. Date of last physical / annual exam _____
Examiner _____
- B. Date of last Pap smear _____
- C. Date of last Cholesterol level _____
- D. Date of last EKG _____
- E. Date of last Chest X-ray _____
- F. Date of last Prostate exam _____
- G. Date of last Complete blood tests _____
- H. Date of last Thyroid level _____
- I. Date of last Sigmoidoscopy or Colonoscopy _____
- J. Date of last Bone density test _____
- K. Date of last Mammogram _____

VI. Name of local pharmacy:

Name: _____ Address: _____

Phone: _____

Mail in Pharmacy:

Name: _____ Phone: _____

Hospital Preference: _____

Lab Preference: _____

NAME : _____

Signature on File, Assignment of Benefits, Financial Agreement

X _____
Patient Name (print):

X _____
DOB:

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Nader Rahmanian, M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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, my signature authorizes releasing the information to the insurer or agency shown. Nader Rahmanian, M.D. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Nader Rahmanian, M.D., if possible or otherwise to me.

3. RELEASE OF INFORMATION Nader Rahmanian, M.D. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Nader Rahmanian, M.D. for reimbursement for services rendered, and (2) any health care provider for continued patient care to Nader Rahmanian, M.D. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical services, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Nader Rahmanian, M.D. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Nader Rahmanian, M.D. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Nader Rahmanian, M.D. if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Nader Rahmanian, M.D. contracts with health care service plans (i.e., PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefits summary the health care service plan furnishes to the patient; and treatment of tests not authorized by the health care service plan. The undersigned agrees to cooperate with to Nader Rahmanian, M.D. to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Nader Rahmanian, M.D. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Nader Rahmanian, M.D. for payment. If an account is sent to any attorney for collection. I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Nader Rahmanian, M.D. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Nader Rahmanian, M.D. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

X _____
Original Date

X _____
Patient Signature / Authorized Party

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

HIPAA CONTACT INFORMATION FORM
and ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

In order to assist you in receiving your health information from
Nader Rahmanian, M.D. please complete this form:

_____ (Initial) I have received a copy of Nader Rahmanian, M.D. privacy notice.

_____ (Initial) Nader Rahmanian, M.D. is permitted to share any medical information with the
individuals listed below, including test results, sensitive information as stipulated by the State of
Pennsylvania, and information disclosed during office visits.

Except: _____

Persons authorized to receive my medical information:
(Include: Full name, relationship, and phone number.)

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

Detailed Messages _____ **Call Back Number** _____ **Email** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

Detailed Messages _____ **Call Back Number** _____ **Email** _____

You may notify me with test results, appointment reminders, and other information regarding my
health information as follows:

___ **Detailed Message on answering machine (Phone # _____)**

___ **Detailed Message on work voicemail (Phone # _____)**

___ **Detailed Message on cell phone (Phone # _____)**

___ **Email Address** _____

I understand and direct that this authorization will remain in effect until it is revoked by me in
writing.

X _____ X _____ X _____ X _____
Printed Name **DOB** **Signature** **Date**

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

Renewal Date: _____ Signature: _____

This authorization is not valid for the request of printed copies of your medical records. You and only you (or your
Legal personal representative) must sign a Health information Release form to obtain copies of your medical
records.