MARIJUANA **MEDICAL**

A Division Of:
Advanced **I**nternal **M**edicine Group, PC
Dr. Leon Schwechter | Dr. Javier Morales | Dr. Craig Grobman
2200 Northern Boulevard, Suite 133
East Hills, New York 11548
Tel: 516-352-8100 | Fax: 516-352-7348

Dear New Patient:

We welcome you to our practice and look forward to a long and healthy relationship.

As you may know, our practice concentrates on very individualized care for each and every patient. Advanced Internal Medicine Group is known for the time given to each patient according to individual needs.

To help us achieve these goals, please complete the enclosed medical history questionnaire and bring all current medications with you. This will help us focus on your health and associated problems.

PLEASE REMEMBER TO BRING YOUR INSURANCE CARDS SO WE CAN MAKE A COPY FOR OUR RECORDS.

Also enclosed please find our cancellation policy and patient financial responsibility form. Unfortunately, we have found it necessary to institute such a policy for optimum use of our schedule and patient care. Please sign and return the cancellation policy and patient financial responsibility form as soon as possible.

Should you have any questions or concerns, please feel free to call our office. We are in the office on Monday from 10am to 8 pm, and 9 am to 5pm on Tuesday, Wednesday, Thursday and Friday. We are closed Saturday and Sunday**. If there is an emergent situation, please call the office and press option 2 or directly follow the prompts**. Your emergency will be addressed as soon as the physician is alerted. Our staff is available to assist you in any way possible.

Sincerely yours,

Doctors and Staff

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Cancellation Policy

It has become necessary to institute a cancellation policy for our office.

New Patient appointments are scheduled for extended periods of time. When these appointments are cancelled without sufficient notice or good cause, it leaves a void in the schedule that could otherwise have been filled by a patient in need. This causes delays in patient care and increases administrative burden on our practice.

If an appointment for a new patient is missed or cancelled with less than 24 hours notice, the patient will be responsible for a $150 charge, which is not covered by the insurance carrier. This amount reflects only a fraction of the cost and inconvenience to the practice. To assist in avoiding this, our office will attempt to contact you prior to this time period to confirm your appointment. In the event a message or voicemail is left for a patient without a response or return call, this will represent a *confirmed* appointment on the patient's behalf.

Similarly, existing patients will be billed $25 for a missed appointment or a late cancellation. If a second occurrence follows, you will be billed $50 and a third will be billed $75 and run the risk of discharge from the practice. If you believe there is good cause for cancellation, please tell the Care Coordinator immediately so that the practice can take it under consideration.

We at Advanced Internal Medicine Group, P.C. realize that unpredictable circumstances occur and we plan to enforce this policy with the highest level of integrity and understanding.

Please sign below to express that you have read, understand and agree to terms listed above.

_____ _____

Signature Date

_____ _____

Name (Print) Relationship to Patient (if other)

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Patient Financial Responsibility Form

Our Billing Process

To help understand the insurance process we felt it necessary to outline our billing process to you.

- If your insurance plan requires a copay, then your copay will be collected in the office at the time of service.
- Your remaining balance is sent to your insurance provider.
- Once the claim is processed, you and our billing team will receive an Explanation of Benefits (EOB) from your insurance company.
- If that EOB states that you have further responsibility for non-covered services such as co-insurance, deductibles or checks from the insurance company that has been sent directly to the patient, we will mail you a statement reflecting the remaining balance which is due upon receipt.

_____ _____

Patient Name Date

I understand and agree that my copay is due at the time of service and my co-insurance and deductibles are due at the time my statement is received. I understand that these charges are my financial responsibility.

_____

Signature

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Patient Financial Responsibility Form

Our Patient Financial Responsibility Form requires that we keep and maintain your credit card information on file. We will use this information only if you are delinquent in responding to our billing statements after 90 days or for preauthorized payment plans.

- Medicare deductible and/or coinsurance _____ **(Patient initials)**
- Insurance deductible/copay _____ **(Patient initials)**
- Non- Covered vaccinations _____ **(Patient initials)**
- Checks sent to me by the insurance company _____ **(Patient initials)**
- Cancellation Fees _____ **(Patient initials)**

I,_____, authorize **Advanced Internal Medicine Group, P.C.** to keep my signature and credit card information on file and to charge my account for balances that remain unpaid ninety (90) days following the service.

_____

Patient Name

_____

Cardholder Name

_____

Credit Card Account Number Expiration Date CVV

_____

Cardholder Signature

Medical History Form

NAME:_____**DATE:**_____

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

PHONE HOME:_____ **WORK:**_____ **CELL:** _____

SS#:_____ **EMAIL:**_____**DATE OF BIRTH:** _____

WOULD YOU LIKE US TO ENABLE YOU TO USE OUR PATIENT PORTAL TO ALLOW YOU TO FOLLOW YOUR MEDICAL PROGRESS? YES ☐ / NO ☐

Whom can we thank for this referral_____

Name of Insurance Carrier:_____ **Please discuss with office staff prior to visit**

Date	Please list any Surgeries

Date	Please list any Medical Conditions

Medications with Dose and Frequency Include Over the Counter and Vitamin/Supplements		

Medical History Form

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Drug Allergies (*or side effects/reactions*): _____

_____

Family History-Place X in appropriate boxes and/or fill in information									
Relative	Alive	Deceased	Age	Cancer	Diabetes	Heart	Hypertension	Mental Illness	Stroke
Father									
Mother									
Brother									
Sister									
Son									
Daughter									

Habits

Smoking: Do you smoke now? _____ Ever? _____

How much? _____If yes, how many packs per day? _____

Occupation: _____Exercise: ☐ Yes. ☐ No. If yes, how many times per week? ____

Caffeine intake: _____cups per day.

Please list any other current physicians and their specialty:

Physician: (ie: First, Last)	City Office is Located in:	Specialty:

General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Gain		
Weight Loss		
HEENT		
Headaches		
Visual Changes		
Dizziness		
Nasal Discharge		
Vertigo (spinning)		
Hoarseness		
Hearing Changes		
Ear Pain		
Nose Bleed		
Ringing in the Ears		
Sore Throat		
Cardiovascular		
Chest Pain		
Shortness of Breath with exertion		
Swelling in Legs		
Palpitations		
Sudden SOB while sleeping		
Exertional Sweats		
Leg Cramps when walking		
Respiratory		
Congestion		
Shortness of Breath		
Expectoration (Producing Phlegm)		
Cough		
Coughing up Blood		
Shortness of Breath while lying flat		
Wheezing		
Gastrointestinal		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea		
Constipation		
Change in bowel habits		
Anorexia		
Rectal Bleeding		
Vomiting Blood		
Trouble Swallowing		
Reflux		

Genitourinary	No	Yes
Sudden Urge to Urinate		
Frequent Night Time Urination		
Incontinence		
Blood in Urine		
Difficulty Urinating		
Frequency of Urination		
Painful Urination		
Musculoskeletal		
Serious Joint/Bone Injuries		
Back Pain		
Joint Stiffness		
Muscle Pain		
Painful Joints		
Swollen Joints		
Hematology		
Anemia		
Prolonged Bleeding		
Recent Transfusion		
Swollen Lymph Nodes		
Skin		
Ulcers		
Psoriasis		
Blistering of Skin		
Discoloration		
Hives		
Moles		
Nodules		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Trouble Maintaining Balance		
Difficulty Speaking		
Fainting		
Headache		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Agitation		
Disorientation		
Anxiety		
Hallucination		
Depression		
Insomnia		
Suicidal thoughts		

AUDIT-C Questionnaire

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Medical History Form

Pharmacy Information

Name of Pharmacy _____

Address _____

Phone # _____ Fax # _____

****If your pharmacy has any questions regarding your prescriptions i.e medication refills, please make your pharmacy aware they **MUST** call our office and speak to one of our Care Coordinators. Our office **does not** receive Escript medication requests/refills. _____ (**Patient initials**)*

Emergency Contact Information

Name_____Relation_____

Address_____

Phone #_____

Race and Ethnicity questions: **The following questions are required to be asked by Medicare. You may answer or decline to answer, but we must place an answer in your medical chart.**

Race (check one)

White ☐ Hispanic ☐ Black ☐ Asian ☐

Native Hawaiian or Pacific Islander ☐ Other Pacific Islander ☐ African American ☐

American Indian Alaskan Native ☐ Decline to answer ☐

Ethnicity (check one) Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer ☐

Preferred Language _____

Do you consent to release prescription data to your doctor from external sources? Yes ☐ / No ☐

Do you consent to release your medical information if needed to help adjudicate a claim dispute? Yes ☐ / No ☐

Do you consent to report your immunizations? Yes ☐ / No ☐

Patient Signature _____ **Date**_____

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NOTICE OF PRIVACY PRACTICES

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.

Keeping your health information confidential and secure and using it only as permitted by law is a top priority of Advanced Internal Medicine Group, P.C. You have the right to know how Advanced Internal Medicine Group, P.C. uses and discloses you health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Advanced Internal Medicine Group, P.C. can use you health information for Treatment, Payment and Health Care Operations. In connection with "Treatment", we may use or disclose your health information to other physicians or other healthcare providers who may be treating you. In connection with "Payment", we may use and disclose your health information to facilitate payment by health insurers. In connection with "Health Care Operations", we may use and disclose your health information to facilitate our business operations. We may also contact you by telephone to remind you of appointments.

Certain uses and disclosures that do not fall under Treatment, Payment, or Healthcare Operations will require your written authorization. For example, if you would like us to send information to an employer, your written authorization may be required. If you wish us to discuss your information with a family member, it will require your written authorization.

We value our patients and the various rights afforded to them under federal and state law to access health information. We recognize and will accommodate patients' rights to restrict the disclosure of health information. We will also accommodate patients' rights to receive confidential communications of their health information. If you wish a copy of this Notice of Privacy Practice, one will be provided.

Advanced Internal Medicine Group, P.C. values its patients. In the event there are any issues or problems regarding the way your health information was handled by us, you may submit them to us in writing or contact our Practice Manager.

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PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been offered a copy of the Notice of Privacy from Advanced Internal Medicine Group P.C. and understand my patient rights.

Date: _____

_____
Signature

_____
Print Name

ASSIGNMENT OF BENEFITS

I authorize and assign directly all payments for my medical care to Advanced Internal Medicine Group, PC. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
Should payment be sent to me, I will send both the payment and the explanation of benefits to Advanced Internal Medicine Group, PC in a timely manner.

Date:_____

_____
Signature

_____
Print Name

MARIJUANA **MEDICAL**

RECORDS RELEASE AUTHORIZATION

TO_____

DOCTOR OF HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Advanced Internal Medicine Group, P.C.
D.B.A. Marijuana Medical
2200 Northern Blvd, Suite 133
East Hills, NY 11548
Tel 516-352-8100 - Fax 516-352-7348

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION. CONCERNING MY ILLNESS AND/OR

TREATMENT DURING THIS PERIOD FROM _____ TO_____

NAME_____DATE_____

ADDRESS _____

SIGNATURE _____ WITNESS_____

(IF RELATIVE, STATE RELATIONSHIP)

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CONTROLLED SUBSTANCES CONSENT FORM

The administration of any controlled substance or narcotic medication is strictly decided by the physician. If in the instance a narcotic is prescribed the following guidelines must be followed and understood by all patients.

The risks of taking a controlled substance include, but are not limited to, drug dependency, addiction, respiratory problems, depression, liver and/or kidney damage, death, etc.

Patients agree to take medications only as prescribed and also agree to notify the physician if the patient does not comply. By agreeing to take the medications as directed, patient is agreeing to random urine and/or blood test to assess compliance.

Patient understands that random urine drug screens may be performed at any given office visit to monitor prescribed medication.

Patients understand that the test results and interpretation will become part of the medical record. Patient's insurance company may discover the results of this test by obtaining a copy of patient's medical records.

Lost, stolen, or misplaced prescriptions will NOT BE REPLACED.

Patients agree that if they deviate from the above guidelines that the physician owns the right to taper off or discontinue the narcotic. Failure to comply with the guidelines also could result in immediate termination from this practice.

By signing this, patient is expressing his/her understanding and agreement with these guidelines.

_____ _____

Patient Signature Date