Advanced **I**nternal **M**edicine Group, PC
Dr. Leon Schwechter | Dr. Javier Morales | Dr. Craig Grobman | Dr. Neena Shah
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.

We concentrate on preventive medicine and early detection of any illness thus minimizing any effects the disease may have on the body. Good health and quality of life are our primary goals.

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 forms. 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. Our phones are answered on Monday from 10am to 8 pm, and on Tuesday, Wednesday, and Thursday from 9 am to 5pm. We are closed Friday through Sunday**.** Our dedicated staff is eager to assist you. **If there is an emergent situation at any time, 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.

Sincerely yours,

Doctors and Staff

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? Y / N

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

Drug Allergies (or side effects/reactions) -_____

Have you ever had Congestive Heart Failure or water in the lungs? Yes_____No _____

If Yes, When was your last echocardiogram and where was it performed? _____

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								

Preventative Medical/Immunization History-*Place X where appropriate and fill in date*									
	Pneumovax	Prevnar	Flu Vaccine	Tetanus	Tetanus with pertussis	Shingles vaccine	Colonoscopy	Mammogram	Bone Density
Yes									
No									
Year done									

Medical History Form

General	N	Y
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 Shortness of Breath 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		

Smoking History

Do you smoke now? _____ How much? _____

Ever? _____ If yes, how many packs per day and when did you quit? _____

(AUDIT C)

How often do you have a drink containing alcohol?

☐Never ☐Monthly ☐2-4 times per month ☐2-3 times a week ☐4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more

How often do you have six or more drinks on one occasion?

☐Never ☐Less than monthly ☐ Monthly ☐Weekly ☐Daily or almost daily

How many hours of sleep do you usually get?_____hours

Do you snore or has anyone told you that you snore? ☐Yes ☐No

Please list any other current physicians and their specialty:

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

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 #_____

Health Care Proxy Information (if you are not aware of what this is, please ask the Provider)

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____ African American____ Asian____

Native Hawaiian or Pacific Islander___ Other Pacific Islander____

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? Y? / N?

Do you consent to release your medical information if needed to help adjudicate a claim dispute? Y? / N?

Do you consent to report your immunizations? Y? / N?

Patient Signature _____ **Date** _____

I give my consent for Advanced Internal Medicine Group, P.C. to all of the listed requests below. Please initial next to each one and sign on the bottom.

_____ ***Controlled Substance Monitoring-***

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

_____ ***Immunization-***

I agree to release my immunization(s) record(s) to New York State Immunization Information System (NYSIIS).

_____ ***Patient Financial Responsibility Form***

If your insurance plan requires a copay, then your copay will be collected in the office at the time of service. 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 you, we will mail you a statement reflecting the remaining balance which is due upon receipt.

_____ ***Cancellations-***

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. 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.

_____ ***CCM-***

If you are a patient with two or more chronic conditions, or develop two or more chronic conditions, and if you have Medicare you will be enrolled in a program known as Chronic Care Management. We will bill Medicare for providing you with chronic care management up to once a month. If your secondary doesn't participate, you may be charged a coinsurance.

_____ ***Fees for Injections -***

All Injections are put through insurance (Except tetanus, as no insurance covers this). If your insurance does not cover the shot you will be responsible for the cost. If you have any questions on the injection you receive please do NOT hesitate to speak with our billing department.

_____ ***Fees for Patient Testing -***

Your doctor may want to perform various methods of testing which all are submitted to your Insurance. Your responsibility for these costs are the same as your general financial responsibility. You may at any time refuse testing or discuss possible costs with our billing department.

_____ _____

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

RECORDS RELEASE AUTHORIZATION

TO_____

DOCTOR OF HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Advanced Internal Medicine Group, P.C.

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)