



A Division Of:
Advanced Internal Medicine Group, PC
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Tel: 516-352-8100 | Fax: 516-352-7348

Primary Care Patient

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 return it via fax at (516) 918-9039 or email care@aimgroupc.com**. Have all current medications available at the time of the appointment. This will help us focus on your health and associated problems during our visit.

PLEASE REMEMBER TO HAVE YOUR INSURANCE CARDS AVAILABLE 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. We are closed Friday-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,

Providers and Staff



This page MUST be signed to continue receiving services from AIM Housecalls.

Signature _____ Print _____ Date _____

Patients Name (If not self) _____ Relationship to patient _____

I acknowledge that I am aware of the following Advanced Internal Medicine Group, P.C. policies:

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.

Patient Financial Responsibility Form

Following the processing of your insurance claim, you will be billed for any patient responsibility identified on your Explanation of Benefits (EOB), including copayments, coinsurance, deductibles, non-covered services, and any insurance payments issued directly to you. Payment is due upon receipt of your statement.

Cancellations

If an appointment for a missed or cancelled with less than 24 hours notice, the patient will be responsible for a \$250 charge, which is not covered by the insurance carrier. 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/APCM

If you have Medicare you will be enrolled in two programs known as Chronic Care Management and Advanced Primary Care Management. We will bill Medicare up to once a month for preventive care, coordination, and wellness planning outside of your visit. If your secondary doesn't participate, you may be charged a coinsurance. You do have the right to stop these services at anytime. Only one provider may bill for these services per month. It is appropriate for your PCP to be that provider.

Medical Questions and Care Outside of Scheduled Visits

To ensure safe, thorough, and appropriately documented medical care, clinical questions that require medical judgment - including new symptoms, medication changes, review and interpretation of test results, chronic disease management, completion of most medical forms, and treatment recommendations - require a scheduled office or telehealth appointment unless otherwise determined by your provider. Routine appointment scheduling, routine prescription refill requests (when eligible under our refill policy), and administrative requests do not require an appointment.

Patients enrolled in our Care Management Program may receive additional between-visit care coordination services.

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.

Skilled Nursing Facility - Medicare patients only

If you are at any time in a skilled nursing facility or rehab you must alert our staff upon making your appointment. The time during which you reside at one of these facilities puts you under Medicare's SNF consolidated billing time period. You may see your doctor during this time however we are limited to what testing can be done at this visit for example blood work. Medicare is very strict about this time period and will not pay for blood work. You are responsible for relaying this information to our care coordinator staff so that they can follow the proper protocol. Failing to do so will put you responsible for tests Medicare does not cover.



Insurance Information Sheet

Please be sure to complete and return this Insurance Information Sheet with your new patient packet. If you cannot attach your insurance information below, please email a copy to kelly.aimgroup@gmail.com

Primary Insurance

Attach copy of Primary Insurance here

Secondary Insurance

Attach copy of Secondary Insurance here.

If you do have any tertiary insurance please attach it to this sheet as well. If you have any questions, please do not hesitate to contact our Billing department or speak with one of our Care Coordinators.



COMPLETED BY: _____ RELATIONSHIP TO PATIENT: _____

PATIENT 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

[illegible]

Medical History Form

Name: _____

Date: _____

Drug Allergies (or side effects/reactions) - _____

For diabetic patients only:

Have you had a retinal eye exam in the past two years? Yes _____ No _____ If yes, by whom? _____

Habits-Smoking- Do you smoke now? _____ Ever? _____

How much? _____ If yes _____ packs per day? _____

Occupation: _____

Exercise: _____ Yes, _____ No. If yes--How many times per week? _____

Caffeine intake: _____ cups per day.

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									
Siblings									
Children									

Preventative Medical/Immunization History-Place X where appropriate and fill in date

	Pneumovax	Flu Vaccine	Tetanus	Zostavax Shingles vaccine	Colonoscopy	Mammogram	Bone Density
Yes							
No							
Year done							

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

Tobacco history

Do you smoke now? _____ *Ever?* _____ *How much?* _____ *If yes* _____ *packs per day?* _____

During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Yes ☐ No Comments: _____

During the past 4 weeks, have you experienced bodily pain in general?

☐Yes ☐No Comments: _____

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you got sick and had to stay in bed, needed some help with daily chores, or needed help just taking care of yourself?

☐Yes ☐No Comments: _____

In the past 7 days, did you exercise for at least 3 of them?

☐Yes ☐No Comments: _____

On days when you exercised, for how long (in minutes)? _____ *minutes per day*

Can you get places out of walking distance without help? ☐Yes ☐No

Can you shop for groceries or clothes without help? ☐Yes ☐No

Can you prepare your own meals? ☐Yes ☐No

Can you do your own housework without help? ☐Yes ☐No

Can you handle your own money without help? ☐ Yes ☐ No

Do you need help eating, bathing, dressing, or getting around your home? ☐ Yes ☐ No

During the past 4 weeks, would you consider yourself in good health?

☐ Yes ☐ No Comments:

In the past 4 weeks, would you say things have been going well for you?

☐ Yes ☐ No Comments:

Are you having difficulties driving your car?

☐ Yes ☐ No Comments:

Do you always fasten your seatbelt when you are in a car?

☐ Yes ☐ No Comments:

How often during the past 4 weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up	☐ Yes	☐ No
Trouble eating well	☐ Yes	☐ No
Teeth or dentures	☐ Yes	☐ No
Hearing or problems using the telephone	☐ Yes	☐ No
Tired or fatigued	☐ Yes	☐ No

Are you taking your medications the way you were instructed to?

☐ Yes ☐ No Comments:

Are you confident that you can control and manage most of your health problems?

☐ Yes ☐ No Comments:

Is stress a problem for you in handling things such as your health, your finances, your family, social relationships, or your work?

☐ Yes ☐ No Comments:

In the past 2 weeks have you felt nervous, anxious, or on edge?

☐ Yes ☐ No Comments:

In the past 2 weeks, were you not able to stop worrying or control your worrying?

☐Yes ☐No Comments:

How many hours of sleep do you usually get? _____ hours

Do you snore or has anyone told you that you snore?

☐ Yes☐ No

Please choose one of the following :

(Fall screening)

1. Have you fallen in the past year? ☐ Yes ☐ No
2. One fall with injury in the past year? ☐ Yes ☐ No
3. Two or more falls with injury in the past year? ☐ Yes ☐ No
4. One fall without injury in the past year? ☐ Yes ☐ No
5. Two or more falls without injury in the past year? ☐ Yes ☐ No

Please list any other current physicians and their specialty:

[illegible]

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Circle to indicate your answer)

	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 ☐
---	---	---	--

Name _____

(NOW OR IN THE RECENT PAST)

General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Loss		
Weight Gain		
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		
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		
Trouble Swallowing		
Rectal Bleeding		
Reflux		

Date _____

(NOW OR IN THE RECENT PAST)

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		
Itching		
Moles		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Trouble Maintaining Balance		
Difficulty Speaking		
Fainting		
Memory Loss		
Seizures		
Tingling/ Numbness		
Tremors		
Psychiatric		
Disorientation		
Anxiety/Agitation		
Hallucination		
Depression		
Insomnia		

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 Escrip 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?

Patient Signature _____

Date _____



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 your health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Advanced Internal Medicine Group, P.C. can use your 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.



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.
D.B. A. AIM HOUSE CALLS
2200 Northern Boulevard, Suite
133 East Hills, NY 11548
516-352-8100
Fax (516) 918-9039**

**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)