Advanced **I**nternal **M**edicine Group, PC
Dr. Leon Schwechter
Dr. Javier Morales
Dr. Craig Grobman
Dr. Masooma Sheikh
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. 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 as soon as possible.

Should you have any questions or concerns, please feel free to call our office. Our staff is available to assist you in any way possible. We are in the office on Monday from 11am 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, call the office and please 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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Dear New Patient:

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

New Patient appointments are scheduled for at least one hour. When these appointments are cancelled without sufficient notice, it leaves a void in the schedule that cannot be filled. This causes further delay for others seeking a one hour time slot and increases cost to 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.

Similarly, patients will be billed $25 for a missed or last minute cancelled follow up appointment.

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 signifying that you have read and understand our cancellation policy and agree to follow it to the best of your ability.

PLEASE SIGN AND MAIL THIS PACKET TO OUR OFFICE AT YOUR EARLIEST CONVENIENCE.

I ______________________________have read the cancellation policy and understand it. I agree to follow this policy as stated.

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? 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) -____

For diabetic patients only:

Have you had a retinal eye exam in the past two years? Yes ____No____ If yes, by whom? ______________

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	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		
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		
Unbalanced		
Difficulty Speaking		
Fainting		
Headache		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Agitation		
Disorientation		
Anxiety		
Hallucination		
Depression		
Insomnia		
Suicidal thoughts		

(PHQ-2)

Over the past two 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
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	2	2	3

Tobacco history

Do you smoke now? __________*Ever?*____ *How much?* _________________*If yes, packs per day?*_________________

---

*How much caffeine do you drink every day?*_________ *cups per day?*

(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

---

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 youself?

☐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
Sexual problems ☐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. In the following year have you fallen? ☐Yes ☐ No
2. One fall with injury in the past year? ☐Yes ☐ No
3. Two or more falls 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

Have you received the home safety checklist today? ☐Yes ☐ No

Please list any other current physicians and their specialty:

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

Medical History Form

Pharmacy Information

Name of Pharmacy ____________________

Address ____

Phone # _________________________ Fax # __________________________

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**___________________________________

BEACON HEALTH PARTNERS
HEALTHIER PRACTICES™

Home Safety Check List

Safety Concerns	Creating a Safe Environment
When you walk through a room, do you have to walk around furniture?	☐Ask someone to move furniture so your path is clear
Do you have throw rugs on the floor?	☐Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.
Do you have to walk over or around wires or cords (like lamps, telephones, or extension cords)?	☐Coil or tape cords and wires to the wall so you can't trip over them.
Do you have any steps that are broken or uneven?	☐Call to have loose or uneven steps repaired.
Are you missing a light/or are any lights out of order over your stairways?	☐Have a friend or family replace any missing lightbulbs or call an electrician to have a light placed at the top and bottom of the stairs.
Are any handrails loose or broken? Is there a handrail on only one side of the stairs?	☐Fix any loose handrails or have new ones put on ensuring they are on both sides of the staircases.
Are there things you use often in your kitchen that are on high shelves?	☐Move frequently used items into your lower kitchen cabinets keeping them at waist level if possible.
Is your step stool unsteady?	☐If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.
Do you need some support when you get in and out of the tub or up from the	☐Install grab bars inside the tub and next to the toilet. There are also toilet bowl

toilet?	seat raisers available for purchase as well as self-stick strips that be placed on the floor of the tub or shower.
Is the light near the bed hard to reach?	☐Place a lamp close to bed where it is within arm's reach.
Is the path from your bed to the bathroom dark?	☐Put in a night-light so you can see where you are walking. Some night-lights go on by themselves after dark.

Additional Tips to Prevent Falls

☐Exercise regularly to improve your balance and coordination as long as your doctor tells you this is ok.

☐Have your doctor or pharmacist look at all the medicines you take even the over-the-counter medicines. Some medicines can make you sleepy or dizzy.

☐Have your vision checked at least once per year by an eye doctor. Poor vision can increase your risk of falling.

☐Get up slowly after you sit or lie down.

☐Wear shows both inside and outside of the house. Avoid going barefoot or wearing slippers.

☐Improve the lighting in your home. Put in brighter light bulbs; florescent bulbs are bright and cost less to use.

☐It's safest to have uniform lighting in a room. Hang lightweight curtains or shades to reduce glare.

☐Keep emergency numbers in large print near each phone.

☐Put a phone near the floor in case you fall and can't get up.

☐Think about wearing an alarm device that will bring help in case you fall and can't get up.

Adapted from CDC Check For Safety: A home Fall Prevention Checklist for Older Adults
http://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx?ProgramID=147

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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)

Beacon Interdependent Practice Organization, LLC
Beacon IPA, LLC and Beacon Health Partners, LLP

(Collectively referred to as "Beacon")

Organized Health Care Arrangement

ACKNOWLEDGEMENT OF RECEIPT OF
<u>JOINT NOTICE OF PRIVACY PRACTICES</u>

I acknowledge receipt of the Joint Notice of Privacy Practices from Beacon.

Patient: ____
Print Name Signature Date

Guardian/Conservator: ____
Print Name Signature Date

Staff/Witness Name: ____
Print Name Signature Date

☐ I choose to opt-out of receiving fundraising materials.

INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained.

Patient Name: ____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Joint Notice of Private Practices.

☐ Other: ____
____

Signature of provider representative: ________________________ Date: ____________

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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

Chronic Care Management

If you are a patient with two or more chronic conditions, or develop two or more chronic conditions, you will be enrolled in a Medicare program known as Chronic Care Management. Chronic Care Management enables us to provide ongoing medical care to you throughout the year even when you are not in our office at an appointment.

You agree and consent to the following:

- We will bill Medicare for providing you with chronic care management once a month. If your secondary doesn't participate, you may be charged ten dollars monthly. Please see our billing office with any questions.
- These services should be provided by your Primary Care Doctor. Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

- A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue this service at any time for any reason.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals.

Patient Name ______________________________ Date__________