



Advanced Internal Medicine 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: _____

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		

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 # _____

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 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

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 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.



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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.

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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)



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