# MOHAMMAD JAMIL, P.C., dba I CARE INTERNAL MEDICINE (623) 670-7772

Effective Date of Notice: April 6, 2022

#### PRIVACY NOTICE ACKNOWLEDGMENT AND COMMUNICATION CONSENT

Patient Name:	I	OOB: /	/
PRINT NAME		And the particular and the parti	
Please list the pharmacy you would like to use	including cross streets OR pho	one number:	
List Email Address BELOW for use with our s	ecure patient portal: https://h	ealth.healow.com/ica	reim
☐ I do not have an email ☐ I do not wis	sh to share my email or access my i	records via portal	
We must call you at times to give you what is contact you with this information and if we can		n information. Pleas	e let us know how we can
Can we leave detailed or confidential messages Yes No Voice	on your voicemail? e Number:		
Can we mail test results to your home? Yes No	e rumber.		
Can we send you text reminders?	Number:		
Can we lookup/import your prescription history	y electronically from your pha	armacy?	
Exclusions/Alerts (Please note any information the	nat you do not want released to a	authorized individuals:	
We must call you at times to give you what is cl you regarding lab results, radiology results or o			peak to anyone other than
NAME RELATIO	ONSHIP	PHONE	NUMBER
1)		11101112	HOWDER
2)			
Must Sign Below for all information given: My signature below authorizes communication Mohammad Jamil, P.C., Notice of Privacy Pra	on consent as well as acknowl	edges that I have red	ceived a copy of the
I also acknowledge receipt and have read and provider's participation in both the statewide this information and decline another copy.	understand the Notice of Hea and nationwide Health Inform	alth Information Pranation Exchange (H	ctices regarding my (E), or I previously received
Patient Signature or Authorized Person to Sign		ent: Print name and regal guardian, personal	
Patient Signature or Authorized Person to Sign  ***FOR OFFICE USE ONLY*** We attempted to obtain written acknowledgement of receipt of	(parent, le	gal guardian, personal	
***FOR OFFICE USE ONLY***	(parent, le	gal guardian, personal	





### **HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	Date of Birth:			Todays Date:		
The reason(s) for today's visit:					The period and the Roll do to the Color	
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Patients Age 65+: Have you had any	falls in the last 1 year?	NONE 1 with injury	/ 2+ with injury	1 without injury	2+ without injury	
Please list the most recent date for the	pa following: 18 you bayo					
TEST/EXAM TYPE	Date of last exam: SPECIF		ocedure please w	rite N/A		
Bone Density (age 65+)	Date of last exam:	Ti Hondi / Day / Teal				
Pap Smear- Females (Age 21+)	Date of last exam:		Doctor or	Clinic Name:		
Mammogram-Females (age 40+)	Date of last exam:		DOCTO! OF	Chilic Haile.		
Colon Cancer Screening: (age 45+) Colonoscopy, Cologuard, or FIIT Test	Date of last exam:		Doctor or	Clinic Name:		
Pneumonia Vaccine (age 65+)	Last vaccine date:				ott applett til state til ga en stig i statet til skap melledag professat handlar vedt mes enkeldssan en vend s	
Shingles Vaccine (age 50+)	Last vaccine date:					
Influenza Vaccine (age 18+)	Last vaccine date:					
Surgeries: (You may use the back for						
Surgery Type	additional surgeries)	NONE	energia de la composition de	eranica magazinam anaka	The state of the s	
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NAME:		DOP:				
1 37 31 1 fee 5		DOB:		Date:		

Name the Drug			Strength (mg	, mcg, mL, etc)	Fre	quency taken?						
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	Do you currently use recreational or street drugs?						товового очение домучество		Yes		No	
	Do you use marijuana or THC products?						and the second s		Yes		No	
Social									No			
	How often do you have a drink containing alcohol?							ek:				
The second secon	How many standard drinks containing alcohol						)+					
	How often do you have or more drinks on one o	ccasion	?	er 🗆 Less than	n mor	nthly 🗆 Mor	nthly 🗆 We	eekly [	l Daily	or almo	st da	ily
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Maternal Grandmother											- Committee and the second	



# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name	Date of Bir	th:		
Over the last 2 weeks, how often have you been bothered by	any of the	following prob	lems?	
(Use "x" to indicate your answer)	Not at all	Several days	More than half the days	Nearly ever
	0	1	2	3
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
PLEASE ADD SCORE FOR 1 & 2. If total score is 3 or higher proceed to	questions 3-	9. If your score is	2 or less stop he	re.
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	/e			
7) Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9) Thoughts that you would be better off dead or of hurting yourself in some way				
List any other providers and / or specialis			eing:	
Providers first and last name or clinic name		Diagnosis tr	eated or Spe	cialty
		*		
•				
•				
	-			-
•				
Provider Reviewed:	Date:			



### Please read each policy:

**Controlled Medications:** All narcotic medications will be discussed by <u>appointment only</u> and prescribed at your provider's discretion. Controlled medications being refilled require an appointment every 1-3 months and will only be refilled at the discretion of Dr. Mohammad Jamil

Medication refills: Office visits are required every 1-4 months to monitor the conditions in which you are being treated. At your scheduled office visit, the provider will discuss appropriate monitoring intervals for your medications. Some medications are best monitored with laboratory testing in addition to an office visit. These include cholesterol lowering medication, blood pressure, diabetes medication, and thyroid supplements. Your doctor will advise you when to follow up. Please allow up to three business days for any requests not made during your office appointment. We do not refill medications outside of our business hours.

**No Shows or Cancellations:** As a courtesy to other patients needing appointments, please give us at least 24 hours' notice if you will not be able to make your scheduled appointment time. Excessive abuse of the policy will be subject to a \$25 fee for each no show and your insurance will be notified.

**Payment:** All CO-PAYS, DEDUCTIBLES and BALANCES OWED are due at the time of your appointment. Balances that remain unpaid after 90 days of the initial statement will be subject to being transferred to a collection agency and a 33% fee will be added to the amount owed. However, we do accept monthly payment plans and suggest initiating this so that your account is not sent to collections.

**Forms**: Disability, FMLA, attorney forms, etc. will be reviewed by <u>appointment only</u>. You must bring these forms with you at the time of visit. We do not currently charge for this service; however, we do require all information available for the physician. Please allow up to 7 business days for completion of these forms.

**Inappropriate Behavior:** Inappropriate language (profanity, vulgarity), threats, behavior, and/or harassment (unwelcome contact, whether verbal, nonverbal, physical, or visual that is based on a person's status such as sex, color, race, ancestry, national origin, age, disability, job status or personal characteristics) will not be tolerated and will be grounds for immediate dismissal from practice.

**New Medications**: We do not prescribe new medications without first evaluating a patient. This includes pain medications, antibiotics, medications from other providers or clinics or any other medications that have not already been prescribed by the physician.

Please inform us of any changes to your health history, pregnancy, new medications including antibiotics or any new surgeries at each visit.

Thank you for your cooperation and understanding of our policies.

Name:	Date of Birth:
Signature:	Date: