Name:

DOB:

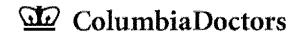
Ⅲ ColumbiaDoctors

Adult New Patient Intake Form

Page 1 of 4

Patient information	
Last Name: First Name:	DOB:
Gender: Home Phone:	Mobile Phone:
Preferred Phone: Home or Mobile (circle one)	cmaii:
Emergency Contact:	Relationship:
Emergency Contact Phone:	Patient Marital Status:
Occupation:	Employer:
Primary Care Provider (PCP):	PCP Phone:
Referring Provider:	Referring Phone:
Preferred Pharmacy:	
Preferred Pharmacy Address:	
Please list ALL active treating physicians (i.e. pulmono Doctor's Name:S	ologist, oncologist, internist, cardiologist, etc)
Doctor's Name:S	pecialty:
Doctor's Name:S _I	pecialty:
Doctor's Name: Sı	pecialty:
monitor and improve the quality of care provided to al	by federal health agencies. This information is used to I patients.
Ethnicity: Race:	
☐ Decline Response ☐ Decline Response	 Black or African American
☐ Hispanic or Latino ☐ American-Indian or Alask	
□ Not Hispanic or Latino □ Asian	□ White □ Other
Preferred Language:	□ Decline Response
Patient Financial Obligation Agreement	
I understand that all applicable copayments and deductible	
responsible and make full payment for all charges not cover	
benefits be paid directly to Columbia Doctors for services re	·
release pertinent medical information to my insurance com	
Notice of Privacy Practices: Acknowledgement of Re	•
I acknowledge that I was provided with a copy of the Colum	
□ Received □ N/A (only if you received the notice from Co	lumbiaDoctors previously)
Information Disclosure and Consent	*
Columbia Doctors will provide you with the health plans tha	
provider who does not accept your health plan, you will be a treatment from that provider.	asked to sign a consent form agreeing that you accept
deathent from that provider.	
I read and agree to all of the above (Financial Agreement,	Notice of Privacy, Insurance Information).
Patient or Legal Guardian Name (Print):	
	Date:
	o for a list of insurances accented by your provider

DOB:



Reason	for too	lay's v	/isit:
--------	---------	---------	--------

General Medical Question	nnaire					
tave you EVER had any o						
Asthma/Breathing Proble	ems 🗆 Y	□N	Heart Diseas	e/Disorder	🗆 Y	□N
Arthritis	🗆 Y	□N	Lung Disorde	er	🗆 Y	οN
Bleeding/Clotting Disord		□N			🗆 Y	
_	🗆 Y	□N	Neurological	Disorder/Chr	onic Headaches 🗆 Y	ΠN
Blood Transfusion	🗆 Y	□N			s 🗆 Y	ΠN
Bowel/Stomach Problem	s 🗆 Y	$\square N$			□ Y	۵N
ancer	u Y	$\square N$	Stroke		🗆 Y	\Box N
Cholesterol Disorder	o Y	□N	Seizure or Ep	ilepsy	🗆 Y	٥N
Diabetes	D Y	□N	Thyroid Diso	rder	🗆 Y	υN
ye Disorder (i.e. Glaucor	ma, cataract) 🗆 Y	□N	Urinary/Kidn	ey Disorder	🗆 Y	ΠN
Nomen Only: Gynecolog	gical Issues 🗆 Y	□N				
Please list all past surgeri Procedure/ Ho	es and hospitalizations a ospitalization	nd the	approximate of Date		Complications	
······································		nd the			Complications	
Procedure/ Ho		tyour	Date			age?
Procedure/ Ho	r conditions/illnesses tha	tyour	Date	nily members Living?	have had: If deceased, at what	age?
Procedure/ Ho	r conditions/illnesses tha	tyour	Date	nily members Living?	have had: If deceased, at what	age?
Procedure/ Hove the Procedure of the Pro	r conditions/illnesses tha	tyour	Date	nily members Living?	have had: If deceased, at what	age?
Procedure/ Horocedure/ Horoced	r conditions/illnesses tha	tyour	Date	nily members Living? □Y□N	have had: If deceased, at what	age?

□Y□N Nausea

DOB:

Columbia Doctors

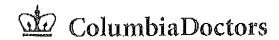
Allergy		Reaction	Allergy	Rea	action
			over the counter medicatio		
Medication Nam	<u>e</u>	Dose	Medication Na	ne	Dose
			J	<u></u>	
Review of Systems					
-	you have	e experienced within	n the past 6 — 12 months.		
	•	•	•		
Constitutional					
⊃Y□N Fever	OYON	Fatigue	□Y□N Weight Gain (Lbs)	□Y□N Sleep Disturb	ances
⊒Y□N Chills	□Y□N	Feeling Poorly	□Y□N Weight Loss (Lbs)	□ Other:	
	□Y□N	Sweats	□Y□N Unexp. Weight Change		
Head, Eyes, Ears, Nose,	and Thi	oat			
□Y□N Vision Problem		Red Eyes	□Y□N Congestion	□Y□N Hoarseness	
□Y□N Decreased Hearing	□Y□N	Eye Pain	□Y□N Snoring	□Y□N Ringing in Ea	ars
□Y□N Double Vision	□Y□N	Runny Nose	□Y□N Dry Mouth	□Y□N Vertigo	
□Y□N Light Sensitivity	□Y□N	Neck Stiffness	□Y□N Flu-Like Symptoms	□Y□N Earache	
∃Y□N Itchy Eyes	□Y□N	Nosebleed	□Y□N Sore Throat	□Y□N Other:	
Cardiovascular					
JY□N Chest Pain		Cold Extremities	□Y□N Irregular Heart Rhythm		
□Y□N Palpitations		Cold Hands or Feet	□Y□N Other:		
□Y□N Leg Swelling		Leg Pain w/ Walking			
		-			
Respiratory				MHMAAA	
□Y□N Shortness of Breath	OYON	Wheezing	□Y□N Coughing Up Blood		
⊐Y⊡N Cough	□Y□N	Shortness of Breath	□Y□N Coughing Up Sputum		
□Y□N Rapid Breathing	□Y□N	Chest Congestion	□ Other:		
Gastrointestinal					
⊒Y□N Abdominal Pain	OYON	Diarrhea	□Y□N Change in Bowels	□Y□N Painful Swal	lowing
JY□N Blood in Stool	□Y□N	Black/Tarry Stools	□Y□N Vomiting Blood	□ Other:	
TVTN Vomiting		Decreased Annetite	□Y□N Bowel Incontinence		

□Y□N Rectal Pain

□Y□N Yellow Skin

Columbia Doctors Name: DOB: □Y□N Constipation □Y□N Trouble Swallowing □Y□N Heartburn Neurological □Y□N Headache □Y□N Unsteady □Y□N Numbness □Y□N Tremor □Y□N Dizziness □Y□N Disorientation □Y□N Tingling □Y□N Memory Lapses/Loss □Y□N Decreased Strength □Y□N Confusion □Y□N Seizures Other: □Y□N Poor Coordination □Y□N Burning Sensation □Y□N Fainting (Syncope) Musculoskeletal □Y□N Joint Pain □Y□N Limb Pain □Y□N Muscle Pain Other: □Y□N Neck Pain □Y□N Joint Swelling □Y□N Muscle Weakness □Y□N Back Pain □Y□N Muscle Cramps □Y□N Leg Swelling Genitourinary □Y□N Frequent Urination □Y□N Pelvic Pain □Y□N Painful Intercourse □Y□N Heavy Period Bleeding □Y□N Incontinence □Y□N Nocturia □Y□N Discharge- Vaginal □ Other: □Y□N Vaginal Bleeding □Y□N Urinary Urgency □Y□N Itching- Genital □Y□N Painful Urination □Y□N Change in Libido □Y□N Irreg. Monthly Cycles Integumentary □Y□N Rash □Y□N Skin Wound □Y□N Unusual Growth □Y□N Skin Cancer □Y□N Itching ☐ Other: □Y□N Dry Skin □Y□N Change in A Mole **Psychiatric** □Y□N Anxiety □Y□N Depression □Other: Hematologic/Lymphatic □Y□N Easy Bruising □Y□N Easy Bleeding □Y□N Swollen Lymph Nodes □ Other: Endocrine □Y□N Excessive Thirst □Y□N Heat Intolerance □Y□N Changes- Skin □Y□N Cold Intolerance ☐ Other: □Y□N Changes-Hair

OFFICE USE ONLY: Provider Signature		Date:	
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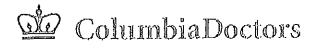
Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:		
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
Doctor's Name:		
Address:		
Phone Number:	Fax Number:	
Specialty:		
Provider Signature:	Date:	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

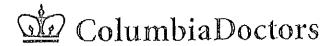
Patient Name	Date of Birth	Medical Record Number
Patient Address	1	
, or my authorized representative, request that health	information regarding my care	and treatment as set forth on this form:
n accordance with New York State Law and the	Privacy Rule of the Health Ins	surance Portability and Accountability Act of 19
HIPAA), I understand that: L. This authorization may include disclosure of infor	nation relative to AI COHOL o	nd DDHC ADHER MENTAL HEALTH
FREATMENT, except psychotherapy notes, and CO	ONFIDENTIAL HIV* RELAT	ED INFORMATION only if I place my initials of
he appropriate line in Item 9(a). In the event the hea	Ith information described below	includes any of these types of information, and I
nitial the line on the box in Item 9(a), I specifically a		
2. If I am authorizing the release of HIV-related, alc	ohol, or drug treatment, or ment	al health treatment information, the recipient is
prohibited from redisclosing such information withou hat I have the right to request a list of people who ma	it my authorization unless permit av receive or use my HTV-related	ned to do so under tederal or state law. I understall information without pull-orization. Let experience
liscrimination because of the release or disclosure of	HIV-related information. I may	confact the New York State Division of Human
Rights at (212) 480-2493 or the New York City Com	mission of Human Rights at (212	2) 306-7450. These agencies are responsible for
protecting my rights.		-
3. I have the right to revoke this authorization at any		
revoke—this authorization except to the extent that a 4. I understand that signing this authorization is volut		
will not be conditioned upon my authorization of this		atominent in a nearth plan, or engineary for benefit
5. Information disclosed under this authorization mig	ht be redisclosed by the recipien	t (except as noted above in Item 2), and this
edisclosure may no longer be protected by federal or	state law.	
5. THIS AUTHORIZATION DOES NOT AUTHO CARE WITH ANYONE OTHER THAN THE AT		
7. Name and address of health provider or entity to	release this information:	
8. Name and address of person(s) or category of per-	an to whom this information wi	1 ha court
a. Traine and address of person(s) of category of per-	son to whom this infolliation wi	n be sent,
9(a), Specific information to be released:		
	to (insert date)	
□ Entire Medical Record, including patient histor		
films, referrals, consults, billing records, insura		
n Other;	Alcohol/Dru	icate by Initialing) a Trantment
######################################	Mental Hea	g Treatment lth Information
	HIV-Relate	ed Information
	Genetic Te	sting
Authorization to Discuss Health Information		<i>:</i>
(b). D By initialing here I authorize		
Initials Name of individual	health care provider	
to discuss my health information with my attorne	y, or a governmental agency, list	red here:
(Attorney/Firm or Governmental A	gency Name)	
10. Reason for release of information:	11. Date or ev	vent on which this authorization will expire:
☐ At request of individual		
□ Other:		
12. If not the patient, name of person signing form:	13. Authority	to sign on behalf of patient;
All Items on this form have been completed and my copy of the form.	questions about this form have b	een answered. In addition, I have been provided
	Data	
nature of Patient or representative authorized by law.	Date:	

^{*} Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects Information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Patient Name:	walking.
Physician Name:	<u> </u>
Department/Practice:	
Designated party:	Designated Party:
Relationship to Patient:	Relationship to Patient:
Address:	Address:
Phone:	
The information will be used or disclosed for the	following purposes:
At the request of the individual	Other
This Authorization grants permission to the De	signated Party (ies) named above to:
have access to my medical record informa	tion
have access to my billing & insurance info	ormation
have access to any test results	
make or confirm appointments	
other, please specify	
 The patient or the patient's representative mus I understand that this information will: (Nexpire I year from the date signed by only when revoked by the patient I understand that I may revoke this author Physician Practice at ColumbiaDoctors; however, if actions taken by ColumbiaDoctors prior to actions taken that this authorization is volumed in the property of the protected by federal prior I understand that once this information is may no longer be protected by federal prior I understand that my treatment cannot be 	flust check one) the patient or patient's representative; or rization at any time by notifying in writing the above named I do revoke the authorization, it will not have any effect on an o their receipt of the revocation untary released to the Designated Party (ies), the released information
Signature of patient or patient's representative (Form MUST be completed before signing or w	Date



Important Information About Patient Email

As a patient of ColumbiaDoctors, you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via email and how ColumbiaDoctors will use and disclose provider / patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are a two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider / patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider / patient email is not available to you and seek medical attention.

Email messages on your computer, laptop, or other device have inherent privacy risks especially when your email access is provided through your employer or when access to your email messages is not password protected.

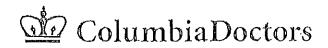
Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. You can also help minimize this risk by using only the email address that you provide to our practice/ program/ provider.

In order to forward or to process and respond to your email, individuals at ColumbiaDoctors other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email message and any and all responses to them may become part of your medical record.



Name of Physician or Program

Patient Request for Email Communications

Patient Name		Date of Birth:
Phone Number	or:	Email Address:
secure. There	is no assurance of confidentiality whe am communicate with you via email you	e email system may not be encrypted and may not b n communicating via email. To request that this must complete this form and return it to your health
Please be advi	sed that;	
•	This request applies only to the heal If you would like to request to comm or program, you must complete a se	theare provider or program that you indicate below unicate via email with another health care provide parate request for that office.
, •	Columbia University Medical Center v specially protected under state and fed health information) via email.	vill not communicate health information that is eral law (e.g., HIV/AIDS, substance abuse, mental
9	You must provide your email address	when registering for your visit with your provider
•	It is recommended that you send a test	email before corresponding via email.
I understand a	nd agree to the following:	
for I ha for I us of I us pro I ag	messages sent to or from this address, ave received a copy of the IMPORTANT in, and I have read and understand it, inderstand and acknowledge that commutem may not be encrypted and may not linformation when communicated via emaderstand that all email communications widing treatment to me.	request is accurate, and that I accept full responsibility INFORMATION ABOUT PATIENT EMAIL nications over the Internet and/or using the email be secure; that there is no assurance of confidentiality ail. may be forwarded to other providers for purposes of iduals associated with it harmless from any and all to this request to communicate via email.
Sig	gnature of patient	Date

Α.	N	of	if	Þ	۰٠
죠.		~	. 11		

B. Patient Name:

C. Identification Number:

NOTE: If Medicare doesn't pay for D. __Services _ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. __Services __ below.

D .	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physician office visits and/or Surgeries	Medicare may not cover because it is not medically reasonable and necessary.	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ______ listed above.
 Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.		
OPTION 1. I want the D listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.		
☐ OPTION 2. I want the D listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.		
☐ OPTION 3. I don't want the D listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.		
H. Additional Information:		

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Ì	signing below means that you have received and under	rstand this notice. You also receive a copy,
ı	I. Signature:	J. Date:
ļ	·	
١		ì

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulévard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.