Dear, patient:

You are scheduled for an appointment with the Irving Radiation Oncology Department.

Your appointment is scheduled for:

Date: ________________________  Time: ________________________

Doctor: ________________________

*Please arrive 30 minutes early for your appointment to complete the registration process.

Please check-in at:
New York Presbyterian Columbia University Medical Center
Department of Radiation Oncology
622 West 168th Street, Basement Level New York, NY 10032
(Attached to this email is Map of the hospital as a guide to our facility and Information about paying for your care)

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:
(Please do not forward the forms to this email)

☐ Insurance card(s)
☐ Valid photo ID
☐ Completed forms listed below (attached):

1. Medication Reconciliation Form (Please list all medications you are currently taking as well as any allergies)
2. Medical History Form/Review of Systems Form (Please complete both pages)
3. Medical History Form (Please complete form)
4. Columbia University and New York Presbyterian Notice of Privacy Practices (Please read through both and sign both acknowledgements)
5. Authorization of Disclosed Protected Health Information/Medical Records form (Make sure to sign the form as we may need to request your medical records)
6. Sexual Health Inventory for Men Form (Please complete form)
7. American Urological Association Urine Symptoms Score Form (Please complete form)

If you have any questions or need to cancel/change your appointment, please call us at (212) 305-7077.
HOW TO FIND RADIATION ONCOLOGY AT NEWYORK-PRESBYTERIAN/COLUMBIA UNIVERSITY MEDICAL CENTER

Note: The Broadway Emergency Department entrance is closed.

Entering from the Harkness Pavilion on Fort Washington Ave. Go through Security. Take the elevator to level 1. Walk toward the Presbyterian Building. Find the sign for Radiation Oncology and make a right towards the Chapel. Make a left and take the Radiation Oncology Elevators down to the department.

Entering from West 168th Street. Go through Security. Walk past the Presbyterian Elevators and go straight through the intersection towards the Chapel. Make a left and take the Radiation Oncology Elevators down to the department.

Entering from Broadway and corner of West 165th St. Go through Security. Walk through the Children's Hospital toward the Presbyterian intersection. Find the sign for Radiation Oncology and make a left towards the Chapel. Make another left and take the Radiation Oncology Elevators down to the department.
MEDICATION RECONCILIATION FORM

1. Do you have any allergies to food or medication?  
(¿Tiene alergia a algún alimento o medicamento?)

☐ Yes (Sí)  ☐ No

If yes, please list them and describe the allergic reactions:  
(Si es si, por favor póngalos en la lista y describa las reacciones alérgicas):

________________________________________________________________________

________________________________________________________________________

2. Are you currently taking any medications?  
(¿Esta usted tomando algún medicamento?)

☐ Yes (Sí)  ☐ No

If yes, please list them (Si es si, por favor de listarlos):

<table>
<thead>
<tr>
<th>Name of Drug (Nombre de Medicina)</th>
<th>Dosage/ Strength (Dosis/Fuerza)</th>
<th>How many times a day? (¿Cuántas veces al día?)</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

REVIEWED BY: ____________________________  DATE: ____________________________

Rev. 12/12/14
## Medical History/Review of Systems

### GENERAL

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent trouble sleeping</td>
<td>Frecuente dificultad para dormir</td>
</tr>
<tr>
<td>Weight gain or loss</td>
<td>Aumento o pérdida de peso</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Pérdida de apetito</td>
</tr>
<tr>
<td>Fever</td>
<td>Fiebre</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Fatiga</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss or change in eye sight</td>
<td>Pérdida o cambio en la visión</td>
</tr>
<tr>
<td>Loss or change in hearing</td>
<td>Pérdida o cambio en la audición</td>
</tr>
<tr>
<td>Bloody nose</td>
<td>Sangrado por la nariz</td>
</tr>
<tr>
<td>Frequent nasal congestion</td>
<td>Frecuente congestión nasal</td>
</tr>
<tr>
<td>Frequent sore throat</td>
<td>Frecuente dolor de garganta</td>
</tr>
<tr>
<td>Frequent hoarseness</td>
<td>Frecuente ronquera</td>
</tr>
<tr>
<td>Dentures</td>
<td>Dentadura postiza</td>
</tr>
</tbody>
</table>

### EYES, EARS, NOSE & THROAT/OJOS, ÓIDOS, NARIZ y GARGANTA

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain or pressure in chest</td>
<td>Dolor o presión en el pecho</td>
</tr>
<tr>
<td>Palpitation or pounding heart</td>
<td>Palpitaciones en el corazón</td>
</tr>
<tr>
<td>Heart trouble</td>
<td>Problemas con el corazón</td>
</tr>
<tr>
<td>High or low blood pressure</td>
<td>Presión arterial alta o baja</td>
</tr>
</tbody>
</table>

### CARDIOVASCULAR

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Estreñimiento</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Diarrea</td>
</tr>
<tr>
<td>Bloody stool</td>
<td>Sangre en la material fecal</td>
</tr>
<tr>
<td>Frequent indigestion/heartburn</td>
<td>Frecuente indigestión/acidex estomacal</td>
</tr>
<tr>
<td>Jaundice or hepatitis</td>
<td>Ictericia o hepatitis</td>
</tr>
<tr>
<td>Piles or rectal disease</td>
<td>Hemorroides o enfermedad rectal</td>
</tr>
<tr>
<td>Stomach, liver or intestinal trouble</td>
<td>Problema estomacal, hepático, intestinal</td>
</tr>
</tbody>
</table>

### GASTROINTESTINAL

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent or painful urination</td>
<td>Micción frecuente o dolor al orinar</td>
</tr>
<tr>
<td>Blood in urine</td>
<td>Sangre en la orina</td>
</tr>
<tr>
<td>Discharge</td>
<td>Flujo o secreción</td>
</tr>
<tr>
<td>Change in sexual functioning</td>
<td>Cambio en el funcionamiento</td>
</tr>
</tbody>
</table>
### MUSCULOSKELETAL/MUSCULOESQUELÉTICO

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swollen or painful joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg cramps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent back pain</td>
<td></td>
<td></td>
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<tr>
<td>Loss of muscle strength</td>
<td></td>
<td></td>
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<tr>
<td>Falls (in the last 3 months)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NEUROLOGICAL/NEUROLÓGICO

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paralysis or weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
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<tr>
<td>Frequent or severe headaches</td>
<td></td>
<td></td>
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<tr>
<td>Nervousness</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling</td>
<td></td>
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<tr>
<td>Dizziness or fainting spells</td>
<td></td>
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<tr>
<td>Loss of memory or amnesia</td>
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</tr>
</tbody>
</table>

### PSYCHIATRIC/PSIQUIÁTRICO

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
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<tr>
<td>Anxiety</td>
<td></td>
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</tbody>
</table>

### RESPIRATORY/RESPIRATORIO

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
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<tr>
<td>Coughed up blood</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Bronchitis</td>
<td></td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Tuberculosis</td>
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</tbody>
</table>

### FEMALE PATIENTS ONLY

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Change in menstrual cycle</td>
<td></td>
<td></td>
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<tr>
<td>Severe cramping</td>
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<tr>
<td>Vaginal discharge</td>
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</tbody>
</table>

### PACIENTES MUJERES SOLAMENTE

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in menstrual cycle</td>
<td></td>
<td></td>
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<tr>
<td>Severe cramping</td>
<td></td>
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<tr>
<td>Vaginal discharge</td>
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</tbody>
</table>

### PAIN ASSESSMENT/EVALUACIÓN DEL DOLOR

<table>
<thead>
<tr>
<th>Question</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have pain?</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Severity Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>No Pain/Ningún dolor</td>
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<td>Moderate/Dolor moderado</td>
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<td>Worst Possible/El peor dolor posible</td>
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</table>

**Patient Signature:**

**Print:**

**Date:**

---

Página 2 de 2
**MEDICAL HISTORY FORM:** Your answers on this form will help your doctor understand your medical needs. Best estimates are fine if you cannot remember the specific details.

### PAST MEDICAL HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>AIDS or HIV</td>
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<td>Anemia</td>
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<td>Asthma</td>
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<td>Back trouble</td>
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<td>Bleeding tendency</td>
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<td>COPD/Emphysema</td>
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<td>Diabetes</td>
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<td>Gastric reflux</td>
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<td>Heart disease</td>
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<td>Hemorrhoids</td>
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<td>Hepatitis</td>
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<td>High blood pressure</td>
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<td>Kidney disease</td>
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<td>Liver disease</td>
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<td>Migraines</td>
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<td>Pneumonia</td>
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<td>Seizures</td>
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<td>Stroke</td>
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<tr>
<td>Thyroid disease</td>
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</tbody>
</table>

Please list any other medical conditions not listed above:

- **Have you ever:**
  - Been diagnosed with Lupus? [ ] Yes [ ] No
  - Been diagnosed with Scleroderma? [ ] Yes [ ] No
  - Been diagnosed with Ulcerative Colitis? [ ] Yes [ ] No
  - Been diagnosed with Crohn’s disease? [ ] Yes [ ] No
  - Received chemotherapy? [ ] Yes [ ] No
  - Had a pacemaker or defibrillator implanted? [ ] Yes [ ] No
  - Have you ever received radiation therapy? [ ] Yes [ ] No

If yes, when? __________________________
If yes, which company? __________________________
If yes, to which body part and when? __________________________
Which hospital? __________________________

### PAST SURGICAL HISTORY

Please list any prior surgeries you have had and the approximate date:

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### FAMILY HISTORY

Have any of your first degree relatives had cancer?

- Mother [ ] Yes [ ] No Type: __________________________
- Father [ ] Yes [ ] No Type: __________________________
- Siblings [ ] Yes [ ] No Type: __________________________
- Children [ ] Yes [ ] No Type: __________________________

### SOCIAL HISTORY

Occupation: __________________________

Marital Status: __________________________

Lives with: __________________________

**Smoking**

- Do you currently smoke? [ ] Yes [ ] No Did you smoke in the past? [ ] Yes [ ] No
  - If Yes to either: Years smoked: ________ Packs per day: ________

**Alcohol**

- Do you currently drink alcohol? [ ] Yes [ ] No If Yes, drinks per day: __________________________

**Other Substances**

- Do you use any other substances? [ ] Yes [ ] No Have you in the past? [ ] Yes [ ] No
  - If Yes, describe use: __________________________

Patient Signature: __________________________

Print: __________________________

Date: __________________________
OUR USES AND DISCLOSURES

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with the federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We do not create or manage a hospital directory.
- In addition to the federal rules regarding health care privacy, we will follow New York State law. For example, we will obtain appropriate written consent from you before we share information concerning genetic information, HIV status, substance abuse treatment, and certain mental health information for purposes other than treating you or obtaining payment for services we provide to you.
- Please ask your physician for information about how to sign up for our patient portal.

OUR RESPONSIBILITY

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office, and on our website.

This Notice covers:
- The faculty practices of Columbia University Medical Center known as ColumbiaDoctors
- Columbia’s physicians, dentists, health care, and allied health professionals when practicing on Columbia University-owned or leased space, as well as their clinical support staff

If you receive treatment at another location, for example NewYork-Presbyterian Hospital, the Notice of Privacy Practices you receive at such other location will apply.

Office of HIPAA Compliance
630 West 168th Street, Box 159
New York, NY 10032
Tel. 212.305.7315  Fax. 212.342.5173
E-mail: HIPAA@cumc.columbia.edu
http://www.cumc.columbia.edu/hipaa/
Effective Date: August 1, 2014

ColumbiaDoctors
YOUR RIGHTS

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 10 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
- We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
- We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

ColumbiaDoctors

continued on next page
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: ______________________

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print)          Patient Signature

If completed by a patient’s personal representative, please print and sign your name in the space below

Personal Representative (Print)    Personal Representative’s Signature

Relationship

For ColumbiaDoctors use only

Complete this section if this form is not signed and dated by the patient or patient’s personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ColumbiaDoctors Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other __________________

Employee Name          Date

This form should be placed in the patient’s medical record

Revised March 2014
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

In addition we will follow New York State rules regarding health care privacy. We will obtain appropriate authorization before we share information concerning reproductive health, HIV status and certain mental health information.

In order to access your health information at your convenience, we urge you to access our patient portal at myNYP.org. Please ask us for information about how to sign up.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.
- Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 23rd, 2013

This Notice of Privacy Practices applies to:
NewYork-Presbyterian Hospital
Compliance & Privacy Office
Get a list of those with whom we've shared Information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using privacy@nyp.org or by calling 212-746-1644.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting the following website: www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.
Date: _______ / _______ / _______   Time: ______________ AM/PM

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

NewYork-Presbyterian Hospital is required by law to protect the privacy of health information that may reveal your identity, and to provide you the health information privacy practices of our Hospital, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Hospital. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

________________________________________
Signature of Patient/Health Care Agent/Guardian/Relative

☐ Patient is unable to sign due to medical reasons
☐ Patient refuses to sign
☐ Other (Please Explain) ________________________________

This Acknowledgement Form will become part of your permanent medical record.
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print): 
Maiden or Other Name (please print): 
Patient Date of Birth: 

Patient Address (please print): 

Telephone (Area Code and Number): 
Email address (please print): 
Medical Record Number: 

New York Presbyterian / Columbia University Medical Center - Department of Radiation Oncology

Address (please print): 
622 W. 168th Street, CHONY North, B-Level, Room 11, New York, NY 10032

Telephone (Area Code and Number): 
Fax (Area Code and Number): 
(212) 305-7077 
(212) 305-5935

Check the name of the Center to disclose information or choose Other Healthcare Provider (specify):
☐ NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital) 
☐ NYPWestwell Cornell Medical Center
☐ NYP/Westchester Division 
☐ NYP/Lower Manhattan 
☐ Other (Provide Name of Entity)

Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form):
Medical Record from (insert date) ____________________ to (insert date) ____________________
☐ Hospital Admission 
☐ Emergency Department 
☐ Ambulatory Surgery 
☐ Outpatient

Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed.
☐ Alcohol/Drug Treatment
☐ Mental Health Treatment (except psychotherapy notes)
☐ HIV/AIDS Related Information
☐ Genetic Testing Information

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference:
☐ CD/DVD
☐ Electronic Delivery

Patients with an active myNYP.org account can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below:
- I have an active myNYP.org account and understand the medical record(s) I requested will be sent to myNYP.org account;
- If my medical record(s) cannot be delivered to myNYP.org account it will be mailed to the above-stated address on CD/DVD

Patient or Personal Representative Initial

The purpose(s) for which disclosure is authorized (check where applicable): 
☐ Individual's request Medical Care 
☐ Insurance 
☐ Immunization 
☐ Legal
☐ Other (specify): 

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as described on this form. I understand that:
- I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
- Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
- Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP will not release your records.
- By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
- I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization.
- I understand that this Authorization will expire on: Date ___/_____/______ (provide date if less than 1 year) or 1 year after being signed.

Signature of Patient/personal representative (e.g., legal guardian) 

Date

If personal representative, print name and relationship to patient

Witness or Notary

538498 (07/14)
### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

#### MEDICAL CORRESPONDENCE UNITS

<table>
<thead>
<tr>
<th>SITE</th>
<th>MAILING ADDRESS</th>
<th>IN PERSON ADDRESS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>NewYork-Presbyterian Hospital / Columbia University Medical Center</td>
<td>622 West 168th Street Medical Correspondence Unit</td>
<td>177 Fort Washington Avenue</td>
<td>(212) 305-3270</td>
</tr>
<tr>
<td>Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital</td>
<td>New York, NY 10032</td>
<td>Milstein Lobby</td>
<td></td>
</tr>
<tr>
<td>(CHONY)</td>
<td></td>
<td>New York, NY 10032</td>
<td></td>
</tr>
<tr>
<td>The Allen Hospital (TAH)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital / Weill Cornell Medical Center</td>
<td>525 East 68th Street Medical Correspondence Unit</td>
<td>525 East 68th Street Room P-04</td>
<td>(212) 746-0530</td>
</tr>
<tr>
<td></td>
<td>Box 126 New York, NY 10065-4879</td>
<td>New York, NY 10065-4879</td>
<td></td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital / Westchester Division</td>
<td>21 Bloomingdale Road Medical Correspondence Unit</td>
<td>21 Bloomingdale Road Main</td>
<td>(914) 997-5725</td>
</tr>
<tr>
<td></td>
<td>Hall H, Room 006 White Plains, NY 10605</td>
<td>Lobby – See Security</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>White Plains, NY 10605</td>
<td></td>
</tr>
<tr>
<td>NewYork-Presbyterian Hospital / Lower Manhattan</td>
<td>170 William Street Medical Correspondence Unit</td>
<td>170 William Street Room M92</td>
<td>(212) 312-5121 and</td>
</tr>
<tr>
<td></td>
<td>Room M92 New York, NY 10038</td>
<td>New York, NY 10038</td>
<td>(212) 312-5122</td>
</tr>
</tbody>
</table>
SEXUAL HEALTH INVENTORY FOR MEN

Patient instructions:
Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify whether you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of responses that best describes your own situation. Please be sure that you select only one response for each question.

During the past 6 months:

1. How do you rate your confidence that you could get and keep an erection?


<table>
<thead>
<tr>
<th>Very low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?


<table>
<thead>
<tr>
<th>Did not attempt intercourse</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

3. During sexual intercourse how often were you able to maintain your erection after you had penetrated (entered) your partner?


<table>
<thead>
<tr>
<th>Did not attempt intercourse</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?


<table>
<thead>
<tr>
<th>Did not attempt Intercourse</th>
<th>Extremely difficult</th>
<th>Very difficult</th>
<th>Difficult</th>
<th>Slightly difficult</th>
<th>Not difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. When you attempted sexual intercourse, how often was it satisfactory to you?


<table>
<thead>
<tr>
<th>Did not attempt intercourse</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Score: _______________

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak with your doctor.

Rev. 12/15/2014
AMERICAN UROLOGICAL ASSOCIATION URINE SYMPTOMS SCORE

Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.

Not at all = 0
Less than 1 time in 5 = 1
Less than half time = 2
About half the time = 3
More than half the time = 4
Almost always = 5

1. INCOMPLETING EMPTYING
   Over the past month, how often have you had a sensation of not Emptying your bladder completely after you have finished urinating?
   Patient Score
   0 1 2 3 4 5

2. FREQUENCY
   Over the past month, how often had you to urinate again less than 2 hours after you have finished urinating?
   0 1 2 3 4 5

3. INTERMITTENECY
   Over the past month, how often have you found you stopped and Started again several times when you urinated?
   0 1 2 3 4 5

4. URGENCY
   Over the past month, how often have you found it difficult to Postponed urination
   0 1 2 3 4 5

5. WEAK STREAM
   Over the past month, how often have you had a weak urinary stream?
   0 1 2 3 4 5

6. STRAINING
   Over the past month, how often have you had to push or strain to begin urination?
   0 1 2 3 4 5

7. NOCTURIA
   Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you go up in the morning?
   (5 or more times, write 5)

TOTAL SCORE

QUALITY OF LIFE DUE TO URINARY SYMPTOMS
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?
Please circle one of the answers below:

Delighted (0)  Pleased (1)  Mostly Satisfied (2)  Mixed (3)  Mostly Dissatisfied (4)  Unhappy (5)  Terrible (6)

Rev. 12/15/2014
Important Information About Paying for Your Care

Health Plan Networks

NewYork-Presbyterian Hospital is a participating provider in many health plan networks. You can find a list of the plans in which we participate at http://nyp.org/payingforcare. Some health plans use smaller networks for certain products they offer so it is important to check whether we participate in the specific plan you are covered by. Our list will tell you if we do not participate in all of a health plan's products.

Physician Services

It is also important for you to know that the physician services you receive in the Hospital are not included in the Hospital's charges. Physicians bill for their services separately and may or may not participate in the same health plans as the Hospital. You should check with the physician arranging your Hospital services to determine which plans that physician participates in.

NewYork-Presbyterian Hospital contracts with a number of physician groups, such as anesthesiologists, radiologists and pathologists, to provide services at the Hospital. Contact information for the physician groups the Hospital has contracted with is available at http://nyp.org/payingforcare. You should contact these groups directly to find out which health plans they participate in.

You should also check with the physician arranging for your Hospital services to determine whether the services of any other physicians will be required for your care. Your physician can provide you with the practice name, mailing address, and telephone number of any physicians whose services may be needed.

Your physician will also be able to tell you whether the services of any physicians contracted by NewYork-Presbyterian Hospital are likely to be needed, such as anesthesiologists, radiologists and pathologists. Contact information for these physicians is available at http://nyp.org/payingforcare. You should contact these groups directly to find out which health plans they participate in.

Hospital Charges

Hospitals are required by law to make available information about their standard charges for the items and services they provide. To obtain information about the Hospital's charges visit us at http://nyp.org/payingforcare.

If You Do Not Have Health Insurance

If you do not have health insurance, you may be eligible for assistance in paying your Hospital bills. Information about financial assistance is available at http://nyp.org/patients/charity-care.html or you may contact our Financial Assistance Office at (866) 252-0101.

(April 2015)