Weill Cornell Medicine NewYork-Presbyterian

Joan and Sanford I. Weill Medical College

Department of Neurological Surgery
525 East 68th Street, Box 99
New York, NY 10065

TODAY'S DATE: (mm/dd/yy)

MEDICAL HISTORY

Physician Name: Please check the name of the physician with whom you have an appointment.

- ☐ Dr. Heidi A. Bender
- ☐ Dr. Srikanth Reddy Boddu
- ☐ Dr. Georgiana Dobri
- ☐ Dr. Pierre Gobin
- ☐ Dr. Jeffrey Greenfield
- ☐ Dr. Caitlin Hoffman
- ☐ Dr. Michael Kaplitt
- ☐ Dr. Jared Knopman
- ☐ Dr. Ning Lin
- ☐ Dr. J Mocco
- ☐ Dr. Rohan Ramakrishna
- ☐ Dr. Amanda Sacks-Zimmerman
- ☐ Dr. Justin Schwarz
- ☐ Dr. Mark Souweidane
- ☐ Dr. Philip Stieg
- ☐ Other

PATIENT INFORMATION

PATIENT NAME (First) | (Middle) | (Last)

ADDRESS Street Name and # | City, State | Zip Code

TELEPHONE (Home): | TELEPHONE (Business): | TELEPHONE (Cell):

GUARANTOR NAME: (First) | (Middle) | (Last)

RELATIONSHIP OF GUARANTOR TO PATIENT: | GUARANTOR DATE OF BIRTH: (mm/dd/yy)

ADDRESS Street Name and # | City,State | Zip Code

TELEPHONE (Home): | TELEPHONE (Business): | TELEPHONE (Cell): | E-MAIL:

DEMOGRAPHIC INFORMATION

DATE OF BIRTH:(mm/dd/yy) | AGE: | SEX: | NAME OF EMPLOYER:

MARITAL STATUS: | PREFERRED LANGUAGE SPOKEN: | OCCUPATION:

REFERRAL INFORMATION

HOW WERE YOU REFERRED? SELECT ONE

☐ WEBSITE ☐ INSURANCE ☐ FAMILY/FRIEND ☐ PHYSICIAN ☐ EMERGENCY ROOM

☐ OTHER *(SPECIFY):*

☐ BRAIN/SPINE ORGANIZATIONS(SPECIFY):

REFERRING PHYSICIAN | PHONE # | FAX #

ADDRESS: (Number, Street, City, State, and Zip)

PRIMARY CARE PHYSICIAN | PHONE # | FAX #

ADDRESS: (Number, Street, City, State, and Zip)

SUB SPECIALIST (1): | PHONE # | FAX #

ADDRESS: (Number, Street, City, State, and Zip)

SUB-SPECIALIST (2): | PHONE # | FAX #

ADDRESS: (Number, Street, City, State, and Zip)

MEDICAL HISTORY (Continued)

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PATIENT NAME

HEALTH INFORMATION

REASON FOR TODAY'S VISIT

OTHER DISEASES AND/OR PROBLEMS.

LIFESTYLE INFORMATION

DO YOU SMOKE?
☐ NO ☐ YES How many packs a day _____ How many years _____ ☐ QUIT - When _____

DO YOU DRINK ALCOHOL?
☐ NO ☐ YES How often _____ How much _____

DO YOU USE RECREATIONAL DRUGS?
☐ NO ☐ YES Which drugs _____ How often _____

DO YOU EXERCISE REGULARLY?
☐ NO ☐ YES How often _____ What type of exercise _____

DO YOU USE CHEWING TOBACCO OR SNUFF?
☐ NO ☐ YES How many years _____ ☐ QUIT - When _____

WHICH HAND DO YOU WRITE WITH?
☐ LEFT ☐ RIGHT

MEDICAL HISTORY

Please check YES or NO if you've experienced any of the following medical problems(select all that apply.

Anemia	☐ yes	☐ no	Fainting	☐ yes	☐ no	Neuromuscular Disease	☐ yes	☐ no
Arm Swelling	☐ yes	☐ no	Galactorrhea	☐ yes	☐ no	Parathyroid Disease	☐ yes	☐ no
Arm Weakness	☐ yes	☐ no	Glaucoma	☐ yes	☐ no	Rashes	☐ yes	☐ no
Asthma	☐ yes	☐ no	Gout	☐ yes	☐ no	Ringing in the Ears	☐ yes	☐ no
Bleeding Tendencies	☐ yes	☐ no	Headaches	☐ yes	☐ no	Seizure Disorder	☐ yes	☐ no
BPH (Enlarged Prostate)	☐ yes	☐ no	Hearing Loss	☐ yes	☐ no	Sexual Problems	☐ yes	☐ no
Cancer	☐ yes	☐ no	Heart Disease	☐ yes	☐ no	Stroke	☐ yes	☐ no
Cataracts	☐ yes	☐ no	High Blood Cholesterol	☐ yes	☐ no	Thrombophlebitis Thyroid	☐ yes	☐ no
Chest Pain	☐ yes	☐ no	Level High Blood Pressure	☐ yes	☐ no	Disease	☐ yes	☐ no
Clotting Disorder	☐ yes	☐ no	HIV	☐ yes	☐ no	Tuberculosis	☐ yes	☐ no
Coronary Artery Disease	☐ yes	☐ no	Increased Thirst	☐ yes	☐ no	Ulcers	☐ yes	☐ no
Diabetes Mellitus	☐ yes	☐ no	Increased Urination	☐ yes	☐ no	Urinary Disorder	☐ yes	☐ no
Difficulty in swallowing	☐ yes	☐ no	Kidney Disease	☐ yes	☐ no	Visual Disturbance	☐ yes	☐ no
Dizziness	☐ yes	☐ no	Leg Swelling	☐ yes	☐ no	Weight Gain	☐ yes	☐ no
Double Vision	☐ yes	☐ no	Leg Weakness	☐ yes	☐ no	Weight Loss,Unintentional	☐ yes	☐ no
Emphysema	☐ yes	☐ no	Memory loss	☐ yes	☐ no			

Other:

PATIENT NAME

FAMILY HISTORY

FATHER:

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

MOTHER:

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

SIBLINGS: - How Many _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

Have you ever been hospitalized for a reason other than surgery? (describe below) ☐ yes ☐ no

REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:

Have you ever had surgery? (describe below) ☐ yes ☐ no

REASON:	WHEN:
REASON:	WHEN
REASON:	WHEN
REASON:	WHEN:
REASON:	WHEN:

MEDICAL HISTORY(Continued)

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PATIENT NAME

MEDICATIONS

Please list any medications you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES PER DAY
1.		
2.		
3.		
4.		
5.		
6.		

HERBAL SUPPLEMENTS OR OVER-THE-COUNTER MEDICINE

Please list any herbal supplements or over-the-counter preparations you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES PER DAY
1.		
2.		
3.		
4.		
5.		

Are you presently taking aspirin or have you taken aspirin in the past 7 days? ☐ Yes ☐ No

ALLERGIES

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to any medications? (if yes, describe below) ☐ Yes ☐ No

NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:

PREFERRED PHARMACY

NAME:	TELEPHONE #:	ADDRESS:

I believe the above information is complete to the best of my knowledge:

Patient Signature: _____ Date: _____

If this form was completed by someone other than the patient, please list name. relationship to the patient and the reason that the patient was unable to complete the form:

HOSPITAL USE ONLY Reviewed and Discussed With Patient:

SIGNATURE Date: _____

Weill Cornell Physicians

Notice of Physician Non-Participation in Your Health Plan

Dear Patient,

You are scheduled for a visit today with a Weill Cornell Physician that does not participate with your health plan. By signing this document you acknowledge that the provider does not participate in your health plan and therefore this and any other visits or services from this provider may result in costs not covered by your health plan.

If you agree to receive healthcare services from this provider, you are entitled to request an estimate of the physician charges for the anticipated services associated with this visit or any planned procedure.

Many Weill Cornell Physicians participate in various health plan networks, although not every physician participates in every plan. You can find a list of the plans in which each physician participates by searching their name here: http:weillcornell.org/ under the tab "insurances".

By providing your signature below, you acknowledge that you have agreed to visits with a non-participating provider.

_____ _____

Signature of Patient or Patient's Representative Date

Weill Cornell Medicine

Financial Policy

Thank you for choosing Weill Cornell Physicians for your health-care needs.

The following is our payment policy which we require you to read and sign prior your visit(s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Site Manager to discuss a satisfactory arrangement.

Participating Plans

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier or a claim can be mailed to you.

Payment in full is due at the time of service for all non-medically necessary services and/or cosmetic services.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for your patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

For your convenience, the following payment methods are accepted:
Cash, personal check, Visa, MasterCard, American Express, Discover

I have read the policy, I understand and agree to it.

_____ _____

Patient Signature Date

_____ _____

Patient Print Date

Weill Cornell Medicine

Weill Cornell Medical College (WCMC)
Privacy Office
Forms

Authorization To Disclose Health Information Via E-Mail

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ ST: ____ Zip: _____ Phone: _____

This authorization covers protected health information (PHI) disclosed by Weill Cornell Medical College (WCMC) personnel to a patient or a patient's representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

****

To be completed by patient or patient's representative:

My signature at the bottom of this form is authorization for WCMC to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Re-disclosure may no longer be protected by law.
- I should not use e-mail for any urgent or time-sensitive medical questions or issues
- Once transmitted, I am responsible for safeguarding the information I receive
- I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a WCMC Revocation of Release of Medical Information Form # PO012B. A revocation will not apply to information that has already been released as a result of this authorization
- To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the WCMC party at the e-mail address below
- I am responsible for notifying the WCMC party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- WCMC will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is: _____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient

****

To be completed by WCMC:

Name of WCMC party (please print): _____

WCMC e-mail: _____

WCMC, please indicate date completed: _____, retain a copy of this request in the patient's file, and provide a copy of the original to the requestor

Weill Cornell Medicine

Authorization To Use or Disclose Protected Health Information (PHI)

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____ (if available)

I authorize the release of the following health information (check below):

- ☐ Entire medical record
- ☐ Diagnostic Tests Date(s): _____
- ☐ Doctor's Notes (from Dr._____) Date(s): _____
- ☐ Lab Results Date(s): _____
- ☐ Pathology Reports_____Specimens _____ Date(s): _____
- ☐ Radiology Reports_____Images _____ Date(s): _____
- ☐ Include Alcohol/Drug Treatment information (initial here) _____
- ☐ Include Mental Health information (initial here) _____
- ☐ Include HIV-Related information (initial here) _____
- ☐ Include Genetic Tests (initial here) _____
- ☐ Other: _____

Who will release/disclose information: Provider: _____

Address: _____

City, State, Zip: _____

Who will receive information: Name: _____

Address: _____

City, State, Zip: _____

How would you like the information delivered:

☐ Secure Email:_____ ☐ Mail to (address above)

☐ Fax: _____ ☐ Upload to Weill Cornell Connect (records available for 90 days)

Reason for Disclosure: _____

This authorization expires: ☐ specific time frame_____, ☐ when record is received, ☐ other (explain)

_____

I understand that:

- By signing this form, I am authorizing the use/disclosure of protected health information as indicated above.
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time by completing a "Request to Revoke an Authorization" form, which is available at Weill Cornell Medicine's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. Weill Cornell Medicine shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements.
- I may request a copy of this signed form.
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment.

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print name Relationship to patient

NewYork-Presbyterian | Weill Cornell Medicine | COLUMBIA — COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

PATIENT Name (please print):	Middle or Other Name (please print):	Patient Date of Birth: / /
Patient Street Address (please print):		Patient Apt/Unit/Suite (please print):
Patient City (please print):	Patient State (please print):	Patient Zip (please print):
Patient Telephone: ( )	Patient Fax Number (if applicable):	Patient Email address (please print):

RECIPIENT Name (please print): **Please check if same as above and skip to next section :** ☐

Recipient Street Address (please print):		Recipient Apt/Unit/Suite (please print):
Recipient City (please print):	Recipient State (please print):	Recipient Zip (please print):
Recipient Telephone: ( )	Recipient Fax Number: ( )	Recipient Email address (please print):

REQUEST REASON, please indicate the purpose of the record release:

☐ Patient Request ☐ Care at another facility/provider ☐ Life Insurance
☐ Legal Purposes ☐ Disability ☐ Worker's Comp
☐ Other (please specify): _____

DISCLOSING ENTITY please check the name(s) of the center(s) to disclose information or choose Other Healthcare Provider and specify:

Hospital/Inpatient Locations

☐ NYP/Allen Hospital ☐ NYP/Lawrence ☐ NYP/Weill Cornell Medical Center
☐ NYP/Brooklyn Methodist ☐ NYP/Lower Manhattan ☐ NYP/Westchester Division
☐ NYP/Columbia University Medical Center ☐ NYP/Morgan Stanley Children's Hospital ☐ Gracie Square Hospital
☐ NYP/Hudson Valley ☐ NYP/Queens

Outpatient/Provider(s) Offices/NYP Physician Medical Groups: For outpatient/physician office records only, please print provider(s) name(s):

☐ Columbia University Irving Medical Center (CUIMC) _____
☐ Weill Cornell Medicine (WCM): _____
☐ NYP Medical Group Brooklyn: _____
☐ NYP Medical Group Hudson Valley: _____
☐ NYP Medical Group Queens: _____
☐ NYP Medical Group Westchester: _____

Ancillary Services

☐ NYP Radiology (imaging only) ☐ Weill Cornell Imaging at NYP
☐ NYP Laboratory (pathology slides only) ☐ Columbia Dental Medicine

Other Healthcare Provider (please specify and print name of provider/entity):

_____

NewYork-Presbyterian | Weill Cornell Medicine | COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

INFORMATION TO BE RELEASED, please specify which medical records should be released:
Dates of Service: from ___/___/___ to ___/___/___ (records will not be released unless Date of Service section is complete)

Medical Records to be Released:

☐ Entire Medical Record ☐ Inpatient/Hospital Records ☐ Outpatient / Provider(s) Office Records ☐ Dental Record

Specific Records to be Released Only:

☐ Hospital Admission Records Only	☐ Operative Reports Only	☐ Discharge Summaries
☐ Emergency Department Only	☐ Ambulatory Surgery Records	☐ Itemized Billing Statement
☐ Radiology Reports Only	☐ Radiology Images/Studies Only	☐ Laboratory Reports Only
☐ Provider Notes Only	☐ Consult Reports Only	☐ Immunization List Only

Other Records to be Released (please specify): _____

ADDITIONAL AUTHORIZATION TO RELEASE SENSITIVE INFORMATION, records containing sensitive information **will be only released** if the appropriate items are initialed by the patient/authorized representative below (each section to be released must be initialed):

_____Alcohol/Drug Treatment/Testing Records _____HIV/AIDS Related Information

_____Mental Health Testing/Treatment (except psychotherapy notes) _____Genetic Testing Information

OTHER COMMENTS/NOTES:

RELEASE METHOD, when possible, we will provide the information you requested electronically please check your preference:

☐ Paper ☐ Fax ☐ Email (unsecure method)

☐ CD ☐ Flash Drive (if available)

☐ Patient Portal Only patients with an active account can request electronic delivery via secure web patient portal at no cost.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS, please review and sign. I, or my authorized representative, request that health information regarding my care and treatment be disclosed as described on this form. I understand that:

1. I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
2. Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
3. Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP/CUIMC/WCM will not release your records.
4. By my specifically authorizing the release of sensitive information (i.e., HIV/AIDS related alcohol or drug treatment, mental health treatment information, and genetic testing information) that the recipient is prohibited from redisclosing 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 sensitive information, I may contact the New York State Division of Human Rights 1-888-392-3644 or the New York City Commission of Human Rights at (718) 722-3131. These agencies are responsible for protecting my rights.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in Item 4 above) and redisclosure may no longer be protected by federal or state law.
6. I may revoke this authorization at any time by providing written notice to NYP/CUIMC/WCM except to the extent that action has already been taken based on this authorization.
7. I understand that this Authorization will expire on (enter date): ___/___/___ or 1 year after being signed.

Signature of Patient/Authorized Representative: _____ Date: ___/___/___

If Authorized Representative, please print name and relationship to patient and provide supporting documentation as appropriate:

Name: _____ Relationship: _____