NYU Langone MEDICAL CENTER
The Center for Musculoskeletal Care
333 East 38th Street • New York, NY 10016

New Patient Information Questionnaire

Page I: Reason for Visit

How old are you? _____Years Old Gender: □ Male □ Female

My pain is on the: □ Right □ Left □ Both Sides

What is the reason for today's visit? Please give complete details of your symptoms.

_____

_____

_____

_____

Was this the result of an accident?

_____

What treatments have you had?

_____

_____

_____

_____

_____

I have reviewed this document in its entirety with the patient.

Physician Signature_____ Date_____

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Page II: Medications and Allergies

List your drug allergies (if any): ☐ No known drug allergies

Drug Name	Allergic Reaction

List your medications: Please include all supplements, herbals, and alternative treatments

Drug Name	Dose	Taken how often?	Date last taken

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Page III: Past Medical History

List of common conditions (check all that apply):

Heart
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Previous Heart Attack
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation or other Arrhythmia
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Stress Test (When? _____)
- ☐ Echocardiogram (When? _____)

Brain and Nervous System
- ☐ Previous Stroke or TIA
- ☐ Alzheimer's or other Dementia
- ☐ Multiple Sclerosis
- ☐ Epilepsy or Seizures
- ☐ Parkinson's Disease

Gastrointestinal
- ☐ GERD/Esophageal reflux/gastritis
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Bleeding from stomach or colon
- ☐ Colonoscopy (When? _____)

Dental
- ☐ Loose Teeth

Psychiatric / General
- ☐ Anxiety
- ☐ Depression
- ☐ Chronic fatigue

Lungs
- ☐ Asthma
- ☐ Emphysema/Chronic Bronchitis/COPD
- ☐ Sleep Apnea
- ☐ Pneumonia (When? _____)
- ☐ Pulmonary Embolism
- ☐ Joints / Musculoskeletal
- ☐ Degenerative Arthritis or Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Osteoporosis

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Recently took Prednisone

Vascular / Heme
- ☐ Previous Blood Clot
- ☐ Previous Blood Transfusion
- ☐ Anemia
- ☐ Varicose veins
- ☐ Bleeding problems
- ☐ Cancer (Specify:_____)

Kidneys
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Urinary Tract Infections
- ☐ BPH
- ☐ Incontinence

Please list all other medical conditions:

_____

_____

_____

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Page IV: Past Surgical History and Hospitalizations

Please list all of the operations that you have had and any complications of anesthesia.

Operation	Date	Hospital	Anesthesia Complications (if any)

Have you ever been to the Emergency Room or admitted to the Hospital for medical reasons?

Date	Hospital	Reason for ER Visit or Hospitalization

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Page V: Family Medical History and Social History

Family Medical History

Relation	Deceased?	Medical Problems
Mother	_____	_____
Father	_____	_____
	How many?	
Brothers	_____	_____
Sisters	_____	_____
Sons	_____	_____
Daughters	_____	_____
	Specify Relation	
Other	_____	_____
Other	_____	_____

Social History

What is your marital status?_____ Do you have children? ☐ Yes ☐ No If yes, how many?_____

Are you working now? ☐ Yes ☐ No What is (or was) your occupation? _____

Have you ever smoked cigarettes? ☐ Yes ☐ No

If Yes: How many packs a day?_____ At what age did you start smoking?_____

Do you smoke now? ☐ Yes ☐ No If no, at what age did you stop?_____

Approximately how many drinks of alcohol do you consume in a week? _____

Who do you live with?_____

Where were you born? _____ If outside the U.S., when did you immigrate? _____

Do you have stairs at home? ☐ Yes ☐ No

Have you used illicit drugs? ☐ Yes ☐ No If yes, which drugs and how recently? _____

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Page VI: Review of Systems

Check all that apply:

General
- ☐ I get tired easily
- ☐ I have night sweats
- ☐ I have fever and/or chills
- ☐ I have recently gained weight
- ☐ I have recently lost weight
- ☐ I have a poor appetite

Eyes
- ☐ I wear glasses or contact lenses
- ☐ I have blurry vision or changes in my vision
- ☐ I have eye pain

Ears, Nose, Mouth & Throat
- ☐ I have ringing in my ears
- ☐ I have hearing loss
- ☐ I have frequent nosebleeds
- ☐ I have seasonal allergies
- ☐ I have nasal congestion
- ☐ I have frequent post-nasal drip
- ☐ I have bleeding gums
- ☐ I have dentures
- ☐ I have jaw pain
- ☐ I have loose teeth
- ☐ I have a hoarse voice
- ☐ I have neck pain
- ☐ I have neck stiffness
- ☐ I have swollen glands in my neck

Respiratory
- ☐ I have a cough
- ☐ I am short of breath when resting
- ☐ I am short of breath when walking
- ☐ I have had Tuberculosis
- ☐ I have frequent wheezing

Neurological
- ☐ I have frequent headaches
- ☐ I have seizures
- ☐ I have dizziness
- ☐ I have a tremor
- ☐ I have numbness and tingling
- ☐ I faint frequently

Psych/Mood
- ☐ I feel depressed
- ☐ I am anxious
- ☐ I have difficulty concentrating
- ☐ I have difficulty sleeping
- ☐ I have mood swings
- ☐ I have hallucinations

Cardiac
- ☐ I have chest pains
- ☐ I have palpitations
- ☐ I have a murmur
- ☐ I have swelling in my legs
- ☐ I can not sleep lying flat

Gastro
- ☐ I have belly pain
- ☐ I have a mass in my belly
- ☐ I have regular heartburn
- ☐ I have trouble swallowing
- ☐ I have frequent nausea and vomiting
- ☐ I have diarrhea
- ☐ I have constipation
- ☐ I have blood in my stool
- ☐ I have a hernia

Kidney
- ☐ I have painful urination
- ☐ I have very frequent urination
- ☐ I am incontinent of urine
- ☐ I have blood in my urine

Musculoskeletal
- ☐ My joints are stiff
- ☐ My joints are swollen
- ☐ I have joint pain
- ☐ I recently broke a bone
- ☐ I have muscle pain

Skin
- ☐ I have a rash

Endocrine
- ☐ I am very thirsty and urinate frequently
- ☐ I am anxious
- ☐ I have hair loss

Heme/Lymph
- ☐ I bruise easily
- ☐ I have had blood clots
- ☐ I have swollen glands

Additional Comments:

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Page VII: Special Medical Conditions

Please check No/Yes even if these conditions were already described elsewhere on this form

Have you had an MI (Myocardial Infarction or "Heart Attack") in the past 6 months?	☐ Yes	☐ No
Have you ever undergone an Angiogram or Cardiac Catheterization procedure? If YES, was a Stent placed? How Many? _____	☐ Yes	☐ No
Do you have a history of CABG or Bypass surgery?	☐ Yes	☐ No
Do you have a history of significant Valvular Heart Disease?	☐ Yes	☐ No
Do you have a history of Heart Failure?	☐ Yes	☐ No
Do you have a history of Cerebrovascular Disease, Stroke or TIA?	☐ Yes	☐ No
Do you have a history of Diabetes treated with Insulin?	☐ Yes	☐ No
Do you have a history of Kidney Disease?	☐ Yes	☐ No
Are you on Dialysis?	☐ Yes	☐ No
Do you have a history of Cirrhosis?	☐ Yes	☐ No
Do you have an Active Cancer or are you currently receiving Chemotherapy or Radiation?	☐ Yes	☐ No
Have you been previously diagnosed with Sleep Apnea?	☐ Yes	☐ No
Do you use a CPAP machine?	☐ Yes	☐ No
Do you use Oxygen at home?	☐ Yes	☐ No
Do you have a history of Blood Clots (DVT or Pulmonary Embolism)?	☐ Yes	☐ No
Do you have a Pacemaker or a Defibrillator?	☐ Yes	☐ No
Are you taking a steroid medication such as Prednisone?	☐ Yes	☐ No
Do you have HIV?	☐ Yes	☐ No
Do you have any Loose Teeth?	☐ Yes	☐ No
Are you taking any Blood Thinners ? (for example: aspirin, Coumadin, warfarin, Pradaxa, Plavix, Xarelto)	☐ Yes	☐ No
Have you ever had a GI (gastrointestinal) Bleed?	☐ Yes	☐ No

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Faculty Group Practice Patient Demographic Form

Patient Information	Name (Last, First, MI)			Today's Date	
	Street Address	City		State	Zip
	Home Phone ( ) ❑ Preferred	Work Phone ( ) ❑ Preferred	Cell Phone ( ) ❑ Preferred		
	SSN / Date of Birth	Gender ❑ Male ❑ Female	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Single ❑ Other		
	Race / Ethnicity	Preferred Language	Email address		
Financially Responsible Party	Is patient responsible party/guarantor? ❑ Yes ❑ No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit.				
	Name	Address	City/ State/ Zip	Relationship to Patient	
	Occupation	Employer	Email address	Date of Birth	
	Home Phone ( ) ❑ Preferred	Work Phone ( ) ❑ Preferred	Cell Phone ( ) ❑ Preferred		
Emergency Contact	Name	Relationship to Patient			
	Home Phone ( ) ❑ Preferred	Work Phone ( ) ❑ Preferred	Cell Phone ( ) ❑ Preferred		
Referral Info	Referring Physician's Name	Physician Phone/Fax (if known)			
	Physician Address				
PCP Info	Primary Care Physician's Name (check if same as Referring Physician above)	Physician Phone/Fax (if known)			
	Physician Address				
Insurance Information	Primary Insurance Co.	Policy #	Group #		
	Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Name of Subscriber (if other than patient)			
	Subscriber's Social Security # / Gender ❑ Male ❑ Female / Date of Birth	Employer of Subscriber	Work Phone ( )		
	Secondary Insurance Co.	Policy #	Group #		
	Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Name of Subscriber (if other than patient)			
	Subscriber's Social Security # / Gender ❑ Male ❑ Female / Date of Birth	Employer of Subscriber	Work Phone ( )		

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient) _____ Date: _____/_____/_____

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Workers Compensation / No Fault Insurance Registration Form

(PLEASE CHECK ONE)

__Workers Compensation __No Fault

PATIENT NAME: _____

NAME OF INSURANCE/COVERAGE: _____

CLAIM ADDRESS FOR INSURANCE/COVERAGE: _____

_____

_____

WCB CASE # _____ OR CLAIM # _____

CARRIER CASE # _____ OR POLICY # _____

DATE OF INJURY/ACCIDENT: _____ TIME OF INJURY: _____

CLAIM MANAGER/ADJUSTER: _____

PHONE #: _____ EXT. _____ FAX #: _____

BODY PART: _____ CURRENTLY WORKING? _____

IF YES, FULL TIME OR PART TIME? _____ IF NO, WHEN DID YOU STOP? _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____

_____

EMPLOYER PHONE NUMBER: _____ EXT. _____ FAX # _____

PLEASE EXPLAIN HOW INJURY OCCURRED: _____

_____

_____

_____

SIGNATURE: _____ DATE: _____

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Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal request to this office for approval.
** Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy

Name of Pharmacy: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Fax Number: _____

Alternate Pharmacy

Name of Pharmacy: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Fax Number: _____

NYU Langone Laboratory

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU Langone Laboratory.**

- LabCorp
- Quest Labs
- NYU Langone Labs
- Other External Location

Please provide name of external location: _____

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Faculty Group Practice Financial Policies and Patient Responsibility

1. **RELEASE OF INFORMATION**: I authorize NYU School of Medicine, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes. _____ **Initials**

2. **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. _____ **Initials**

3. **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

    - My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
    - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
    - I have chosen not to use my health plan coverage. _____ **Initials**

4. **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number _____ **Patient Signature** _____

5. **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor. _____ **Initials**

6. **CANCELLED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancellation fee if I do not provide 24 hour notice of cancellation, or if I do not keep my appointment and have not cancelled. _____ **Initials**

I have been provided the Faculty Group Practice Patient Financial Polices. I understand the information listed above which has been fully explained to me.

_____ _____

Patient Signature **Date**

_____ _____

Guarantor Signature **Date**

NYU Langone MEDICAL CENTER
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NYU Langone Medical Center Electronic Health Information System

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I understand that by signing this form, NYULMC providers directly involved in my care may access my health information, including my electronic prescription records, and that it will be available to my other health care providers in the system, as described in the Fact Sheet.

I acknowledge receipt of the Electronic Health Information System Fact Sheet and consent for all of my providers who participate in the NYU Langone Medical Center Electronic Health Information System to create and/or access and use my electronic health record (EHR) in order to provide my medical care. I understand that this consent will remain in effect unless revoked in writing.

_____	_____
Signature of patient or representative authorized by law	Date
_____	_____
If not the patient, name of person signing this form (please print)	Authority to sign this form on behalf of the patient (example: parent, legal guardian or health care proxy)

School of Medicine
New York University

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.

WHY ARE YOU GETTING THIS NOTICE?

NYU School of Medicine is required by federal and state law to maintain the privacy of your health information. The use and disclosure of your health information is governed by regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the requirements of applicable New York State law. For health information covered by HIPAA, the NYU School of Medicine is required to provide you with this Notice and will abide by this Notice with respect to such health information. If you have questions about this Notice, please contact our Privacy Officer at 877-360-7626.

We will ask you to sign an "acknowledgment" indicating that you have been provided with this notice.

WHO FOLLOWS THE POLICIES IN THIS NOTICE?

The privacy practices described in this notice are followed by:

- Any health care professional who treats you at any of our School of Medicine locations, including our Faculty Group Practices.
- All employees, trainees, students, or volunteers providing services at any of our School of Medicine locations, including our Faculty Group Practices.
- Any business associates of the School of Medicine, including our Faculty Group Practices (See Paragraph 1f on page 4 for a description of business associates.)

WHAT HEALTH INFORMATION IS PROTECTED?

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- Information indicating that you are a patient receiving treatment or other health-related services from our physicians or staff (including at our Faculty Group Practices);
- Information about your health condition (such as a disease you may have);
- Information about health care products or services you have received or may receive in the future (such as an operation); or
- Information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- Demographic information (such as your name, address, or insurance status);
- Unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- Other types of information that may identify who you are.

If you have any questions about this notice or would like further information, please contact your doctor's office.

SCHOOL OF MEDICINE
NEW YORK UNIVERSITY

SUMMARY OF THIS NOTICE

This summary includes references to paragraphs throughout this notice that you may read for additional information.

1. **Written Authorization Requirement.**
   We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. (See paragraph 1 on page 4, Treatment, Payment and Business Operations.) We generally need your written authorization for other uses and disclosures of your health information, unless an exception described in this Notice applies.
2. **Authorizing Transfer of Your Records.**
   You may request that we transfer your records to another person or organization by completing a written authorization form. This form will specify what information is being released, to whom, and for what purpose. The authorization will have an expiration date.
3. **Canceling Your Written Authorization.**
   If you provide us with written authorization, you may revoke, or cancel, it at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the doctor's office where you initially gave your authorization.
4. **Exceptions to Written Authorization Requirement.**
   There are some situations in which we do not need your written authorization before using your health information or sharing it with others. (See paragraphs 2 through 9). They include:
   - **Treatment, Payment and Operations.** As mentioned above, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. (See paragraph 1 on page 4).
   - **Family and Friends.** If you do not object, we will share information about your health with family and friends involved in your care. (See paragraph 2 on page 6)
   - **Research.** Although we will generally try to obtain your written authorization before using your health information for research purposes, there may be certain situations in which we are not required to obtain your written authorization. (See paragraph 3 on page 5)
   - **De-Identified Information.** We may use or disclose your health information if we have removed any information that might identify you. When all identifying information is removed, we say that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive it agrees in writing to protect your privacy when using the information. (See paragraph 4 on page 6.)
   - **Incidental Disclosures.** We may inadvertently use or disclose your health information despite having taken all reasonable precautions to protect the privacy and confidentiality of your health information. (See paragraph 5 on page 6).
   - **Emergencies or Public Need.** We may use or disclose your health information in an emergency or for important public health needs. For example, we may share your information with public health officials at the New York State or city health departments who are authorized to investigate and control the spread of diseases. (See paragraph 6 on page 6.)
5. **How To Access Your Health Information.**
   You generally have the right to inspect and get copies of your health information. (See paragraph 1 on page 8.)
6. **How To Correct Your Health Information.**
   You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. (See paragraph 2 on page 9.)
7. **How To Identify Others Who Have Received Your Health Information.**

You have the right to receive an "accounting of disclosures." This is a report that identifies certain persons or organizations to which we have disclosed your health information. All disclosures are made according to the protections described in this Notice of Privacy Practices. Many routine disclosures we make (for treatment, payment, or business operations among others) will not be included in this report. However, it will identify many non-routine disclosures of your information. (See paragraph 3 on page 9.)

8. **How to Request Additional Privacy Protections.**
You have the right to request further restrictions on the way we use your health information or share it with others. However, we are not required to agree to the restriction you request. If we do agree with your request, we will be bound by our agreement. (See paragraph 4 on page 10.)

9. **How To Request Alternative Communications.**
You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. (See paragraph 5 on page 11.)

10. **How Someone May Act On Your Behalf.**
You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

11. **How to Learn about Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information.**
Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes and genetic information. (See paragraph 2 on page 8).

12. **How To Obtain A Copy of This Notice.**
If you have not already received one, you have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. You can request a copy of the privacy notice directly from your doctor's office. You may also obtain a copy of this notice from our website at www.med.nyu.edu or by requesting a copy at your next visit.

13. **How To Obtain A Copy of Revised Notice.**
We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. You will be able to obtain your own copy of the revised notice by accessing our website at www.med.nyu.edu or by calling your doctor's office. You may also ask for one at the time of your next visit. The effective date of the notice is noted in the top right corner of each page. We are required to abide by the terms of the notice that is currently in effect.

14. **How To File A Complaint.**
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States. Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer at 877-360-7626.

No one will retaliate or take action against you for filing a complaint.

SCHOOL OF MEDICINE
NEW YORK UNIVERSITY

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Treatment, Payment, and Business Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations.

a. Treatment.
We may share your health information with doctors or nurses who are involved in taking care of you. They may, in turn, use that information to diagnose or treat you. A doctor may share your health information with another doctor inside our hospital, or with a doctor at another hospital, to determine how to diagnose or treat you. We may also share your health information with other doctors who referred you to us and/or to whom you have been referred for further health care.

b. Payment.

We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company. This will help us obtain reimbursement after we have treated you, or determine whether your health insurance will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to the hospital for a particular type of surgery. Finally, we may share your information with other health care providers and payers for their payment activities. We may ask for your consent to use or disclose your health information for some or all of these payment activities.

c. Business Operations.
We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use it to educate our staff or medical students and other health care students on how to improve the care they provide for you.

We may also share your health information with other health care providers to help them with their business operations.

d. Appointment Reminders, Treatment Alternatives, Benefits, and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your

health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

e. Fundraising.

To support our business operations, we may use demographic information about you, and the dates that you received treatment or services, in order to contact you to raise money to help us operate. Examples of demographic information include information about your age and gender, where you live or work, and the dates that you received treatment.

Because of the close affiliation between NYU Hospitals Center and the NYU School of Medicine, you may be contacted by either the Hospital or the School, and the health information described above may be shared between the Hospital and the School to carry out joint fundraising activities

f. Education.

The close affiliation established between NYU Hospitals Center and the NYU School of Medicine serves to provide high quality training and education to the health care professionals at both institutions as well as the School's students. This affiliation also offers patients the benefits of receiving care from doctors and other health care professionals who are leaders in research and the development of other advanced treatment therapies. As part of this close affiliation, we may share your health information with health care professionals, medical staff members, employees, trainees, volunteers and other staff members at the NYU Hospitals Center for the Hospital's and School's joint training and education activities.

g. Business Associates.

We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company.

Another example is that we may share your health information with an insurance company, law firm, or a risk management organization in order to obtain professional advice about how to manage risk and legal liability, including insurance or legal claims. We may also share your health information with an accounting firm.

If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

h. Electronic Communications.

In order to communicate information in order to treat you, obtain payment for services, or conduct our business operations, our staff may communicate information about you via email over our network. However, you will not be contacted by email unless we have obtained your authorization to do so, or we are responding to an inquiry that you initiated via email.

2. <u>Family and Friends Involved in Your Care</u>

If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative, or another person responsible for your care about your location and general condition here at the School of Medicine. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. <u>Research.</u>

In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may

use and disclose your health information without your written authorization. To do this, we are required to obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly.

We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our

facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4. Completely De-identified or Partially De-identified Information.

We may use and disclose your health information if we have removed any information that has the potential to identify you, so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you for certain purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number). R&G Comment: partially de-identified information (referred to as a "limited data set" under the regulations) may be disclosed only for public health, research, or health care operations purposes.

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

6. Public Need

a. As Required By Law.

We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

b. Public Health Activities.

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials who are responsible for controlling disease, injury, or disability.

We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease, if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam. This could happen if we were to discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

c. Victims of Abuse, Neglect, or Domestic Violence.

We may release your health information to a public health authority or other authorized governmental authority if we reasonably believe you have been a victim of abuse, neglect, or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

d. Health Oversight Activities.

We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

e. Product Monitoring, Repair, and Recall.

We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

f. Lawsuits and Disputes.

We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

g. Law Enforcement.

We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

h. To Avert A Serious And Imminent Threat to Health or Safety.

We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers: 1) if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or 2) if we determine that you escaped from lawful custody (such as a prison or mental health institution).

i. National Security and Intelligence Activities or Protective Services.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

j. Military and Veterans.

If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

k. Inmates and Correctional Institutions.

If you are an inmate, or if you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers. This may happen if it is necessary to provide you with health care, or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

7. <u>Workers' Compensation.</u>

We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

8. <u>Coroners, Medical Examiners, and Funeral Directors.</u>

In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

9. Organ and Tissue Donation.

In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes, or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

SPECIAL PROTECTIONS FOR CERTAIN TYPES OF INFORMATION

Some kinds of information are considered so sensitive that state or federal laws provide special protections for them. That means that we may have to get your written authorization to disclose (and sometimes to use) these types of information for treatment, payment or health care operations. We may also be required to obtain your written authorization before we can use or disclose these types of information to the government, to law enforcement officers, to courts, to researchers, and to others in the ways that we have explained above in this Notice. The following types of information are subject to special protections under state or federal law:

- Information about genetic testing or the results of genetic testing
- Information about HIV testing or test results
- Information about substance abuse rehabilitation treatment
- Information about mental health treatment or status
- Information contained in certain confidential psychotherapy notes

Your written authorization will generally be required before we may disclose these types of information. However, some exceptions apply. For example, your written authorization is not required for your therapist to use psychotherapy notes to treat you, or to disclose them to others in the course of training programs, for legal defense in an action you bring, for oversight of the therapist by an authorized government agency, or as otherwise required by law. *If you have questions about the ways that these types of information can be used or disclosed, please contact the Privacy Officer at 877-360-7626, or speak with your doctor, counselor, social worker or therapist.*

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters. To exercise these rights, please submit your requests to each of the School of Medicine locations, including the Faculty Group Practices, that you would like to consider your request.

1. Your Right To Inspect and Obtain Copies of Your Records.

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records.

a. How to Make Your Request.

To inspect or obtain a copy of your health information, please submit your request in writing to your doctor's office. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. Cost.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request.

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c. Response Time.

We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

d. If Your Request is Denied.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. **Your Right To Amend Records.**

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records.

a. How to Make Your Request.

To request an amendment, please write to the Practice Manager of your doctor's office. Your request should include the reasons why you think we should make the amendment. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. Response Time.

Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

c. If Your Request is Denied.

If we deny a part of or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the United States Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. **Your Right To An Accounting Of Disclosures.**

After April 14, 2003, you have a right to request an "accounting of disclosures." This report identifies certain other persons or organizations to whom we have disclosed your health information. ***The accounting does not include routine disclosures made for treatment, payment and operations or pursuant to a patient authorization. It also does not include certain other disclosures set forth in Section 3.d. below.***

a. How to Make Your Request.

To request an accounting of disclosures, please write directly to your doctor's office. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. Cost.

You have a right to receive one accounting within every 12-month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

c. Response Time.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

d. What is Not Included in the Accounting of Disclosures?

An accounting of disclosures does not describe every instance in which your health information has been shared.

Specifically, an accounting of disclosures does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health, or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; and
- Disclosures made before April 14, 2003.

4. Your Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had.

a. How to Make Your Request.

To request restrictions, please write to your doctor's office. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. We are Not Required to Agree.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our

agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. **<u>Your Right To Request Alternative Communications.</u>**

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work.

How to Make Your Request.

To request alternative communications, please write directly to your doctor's office. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

NYU Langone MEDICAL CENTER
The Center for Musculoskeletal Care
333 East 38th Street • New York, NY 10016

NYU Faculty Group Practice Notice of Privacy Practices Acknowledgement

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NYU Faculty Group Practice physicians and staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

_____

Print Name of Patient

_____

Signature of Patient (or Financially Responsible Party)

_____

Relationship to Patient

_____

Date