Thank you for choosing

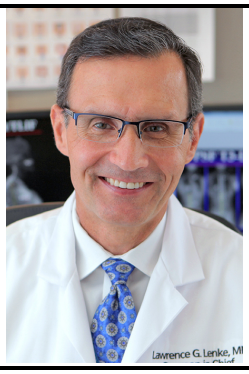
ColumbiaDoctors | Orthopedics

Please complete the information on the following 11 pages so my clinical team and I can better diagnose you.

Pediatric New Patient Intake Form (pg. 1-3)

Pediatric Spine Supplement (pg. 4-5)

Notice of Privacy Practices (pgs. 6-11)

	**YOUR PHYSICIAN**	**PHONE CONTACT**	**CHECK-IN LOCATION**
	Lawrence G. Lenke, MD	P: (212) 932-5100 F: (212) 932-5097	Allen Pavilion - Spine Hospital 5141 Broadway, Rm 3FW-020 New York, NY 10034

Pediatric New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Preferred Phone: _____ Email: _____ Gender: _____

Primary Pediatrician: _____ Phone: _____
Pediatrician Address: _____
Referring Provider: _____ Phone: _____
Referring Address: _____
Preferred Pharmacy: _____ Phone: _____
Preferred Pharmacy Address: _____

Parent 1 Name: _____ DOB: _____
Phone: _____ Email: _____
Occupation: _____ Marital Status: _____ Spouse: _____
Parent 2 Name: _____ DOB: _____
Phone: _____ Email: _____
Occupation: _____ Marital Status: _____ Spouse: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: _____ ☐ Decline Response
Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____
Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

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

Patient Name (Print): _____
Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____
Representative Signature: _____ Date: _____

Medical and Social History

Reason for today's visit:

Are you adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*
Which pregnancy is this child? _____ Birth weight: _____ Born by: □ C-Section □ Vaginal Delivery
Months' gestation at birth? _____ If C-section, why? _____
Please describe any health problems the mother or child experienced during pregnancy or after birth, if any:

Does you have any allergies to medications or other substances? □ Y □ N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL current medications, including over-the-counter, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please list any past surgeries and the approximate date.

Procedure	Date	Reason	Complications

Have you EVER had any of the following?

Anemia/Bleeding tendency ..... □ Y □ N
Asthma/Breathing problems ..... □ Y □ N
Behavioral problems..... □ Y □ N
Blood Transfusion..... □ Y □ N
Bowel/Stomach problems ..... □ Y □ N
Cancer/Leukemia ..... □ Y □ N
Chicken Pox/Shingles ..... □ Y □ N
Developmental disorder ..... □ Y □ N
Diabetes ..... □ Y □ N
Ear/Nose/Throat ..... □ Y □ N
Eczema/Skin disorder ..... □ Y □ N
Eye Disorder ..... □ Y □ N
Growth disorder..... □ Y □ N
Heart disorder/defect ..... □ Y □ N
Kidney/Bladder problems ..... □ Y □ N
Liver disease ..... □ Y □ N
Seizure or Epilepsy ..... □ Y □ N
Thyroid disorder ..... □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Parent:		□ Y □ N	
Parent:		□ Y □ N	
Sibling:		□ Y □ N	
Other:		□ Y □ N	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Does anyone in living in your home smoke? □ Y □ N Do you have pets? □ Y □ N

Do you smoke? □Y □N □Never If Y, Packs/day _____ If N, previously? □Y □N Yrs smoked ____ Packs/day ___

Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If Y, drinks/week _____

Provider Signature: _____ Date: _____

NAME:_____ **DATE:** _____

FILLED OUT BY:_____ **RELATIONSHIP TO PATIENT:**_____

1. Chief complaint: Spinal Deformity: ☐ Scoliosis ☐ Kyphosis ☐ Spondylolisthesis ☐ Other _____
   (check all that apply): ☐ Neck pain Arm: ☐ Pain ☐ Numbness ☐ Weakness
   ☐ Back pain Leg: ☐ Pain ☐ Numbness ☐ Weakness

2. How was your spinal deformity discovered? _____

3. Do you know your present curve measurement(s)? _____

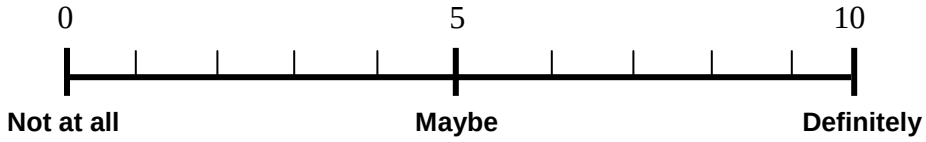
4. Growth in the past 6 months_____
   Height of Mother:_____ Father:_____ Siblings:_____

5. Does the patient have numbness or weakness in his/her legs? ____ Yes ____ No

6. Are there any problems with loss of bowel or bladder control? ____ Yes ____ No

7. Reason(s) for seeking treatment at this time: ☐ progressive deformity ☐ pain ☐ can't stand straight
   ☐ I don't like the appearance of my back/waistline ☐ Other: _____

8. If recommended, please rate how interested you are in having surgery to treat your problem:



Is there any other information that the doctor should be aware of?

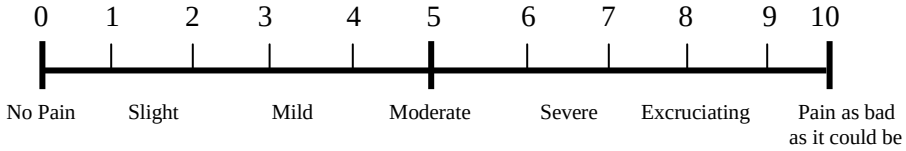
_____

_____

_____

_____

IF THERE IS SPINAL PAIN PRESENT, HOW WOULD YOU RATE IT? (**circle number)**



01. Pain Intensity
- ◯ I can tolerate the pain I have without having to use pain killers.
- ◯ The pain is bad but I manage without taking pain killers.
- ◯ Pain killers give complete relief from pain.
- ◯ Pain killers give moderate relief from pain.
- ◯ Pain killers give very little relief from pain.
- ◯ Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing, etc.)
- ◯ I can look after myself normally without it causing extra pain.
- ◯ I can look after myself normally but it causes extra pain.
- ◯ It is painful to look after myself and I am slow and careful.
- ◯ I need some help but manage most of my personal care.
- ◯ I need help everyday in most aspects of self care.
- ◯ I do not get dressed, wash with difficulty and stay in bed.

03. Lifting
- ◯ I can lift heavy weights without extra pain.
- ◯ I can lift heavy weights but it gives extra pain.
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table.)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

04. Walking
- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me walking more than 1 mile.
- ◯ Pain prevents me walking more than 1/2 mile.
- ◯ Pain prevents me walking more than 1/4 mile.
- ◯ I can only walk using a stick or crutches.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting
- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting more than one hour.
- ◯ Pain prevents me from sitting more than thirty minutes.
- ◯ Pain prevents me from sitting more than ten minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing
- ◯ I can stand as long as I want without extra pain.
- ◯ I can stand as long as I want but it gives extra pain.
- ◯ Pain prevents me from standing more than one hour.
- ◯ Pain prevents me from standing more than thirty minutes.
- ◯ Pain prevents me from standing more than ten minutes.
- ◯ Pain prevents me from standing at all.

07. Sleeping
- ◯ Pain does not prevent me from sleeping well.
- ◯ I can sleep well only by using tablets.
- ◯ Even when I take tablets I have less than six hours sleep.
- ◯ Even when I take tablets I have less than four hours sleep.
- ◯ Even when I take tablets I have less than two hours sleep.
- ◯ Pain prevents me from sleeping at all.

08. Employment/Homemaking
- ◯ My normal homemaking/job activities do not cause pain.
- ◯ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ◯ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g. lifting, vacuuming).
- ◯ Pain prevents me from doing anything but light duties.
- ◯ Pain prevents me from doing even light duties.
- ◯ Pain prevents me from performing any job or homemaking chores.

09. Social Life
- ◯ My social life is normal and gives me no extra pain.
- ◯ My social life is normal but increases the degree of pain.
- ◯ Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g., dancing, etc.).
- ◯ Pain has restricted my social life and I do not go out as often.
- ◯ Pain has restricted my social life to home.
- ◯ I have no social life because of pain.

10. Traveling
- ◯ I can travel anywhere without extra pain.
- ◯ I can travel anywhere but it gives extra pain.
- ◯ Pain is bad but I manage journeys over two hours.
- ◯ Pain restricts me to journeys less than one hour.
- ◯ Pain restricts me to short journeys under thirty minutes.
- ◯ Pain prevents me from traveling except to the doctor or hospital.

****

Please take time to review the questionnaire for completeness.
Your complete medical information is very important to us!
Thank you!

Patient/Parent Signature	Date	Physician Signature	Date

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.

About this notice

This Notice will tell you about the ways we may use and disclose health information that identifies you ("Health Information"). We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your Health Information; and follow the terms of our Notice that are currently in effect. This Notice covers the faculty physician practices of Columbia University Medical Center known as ColumbiaDoctors, all Columbia owned or controlled physician, dental, allied health professional offices and/or other faculty practice plans, as well as Columbia's employed faculty physicians, dentists and allied health professionals when practicing on Columbia University owned or leased space, as well as their clinical support staff.("Columbia University", "Columbia", "we" or "us") (If Columbia physicians or health care professionals provide you with treatment or services at another location, for example New York Presbyterian Hospital, the Notice of Privacy Practices you receive at such other location will apply.

How we may use and disclose health information about you

The following categories describe different ways that we may use and disclose Health Information.

For Treatment

We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process. Different departments of Columbia University also may share Health Information such as prescriptions, lab work and x-rays to coordinate your treatment. We also may disclose Health Information to people outside Columbia University who may be involved in your medical care.

For Payment

We may use and disclose Health Information so that we may bill for treatment and services you receive at Columbia University and can collect payment from you, an insurance company or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. In the event a bill is overdue we may need to give Health Information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use Health Information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this Notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatment Alternatives/ Health-Related Benefits and Services
We may use and disclose Health Information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities
Columbia University Medical Center (CUMC) may use your demographic information, including name, address, health insurance status, age, and gender, as well as certain treatment information, including the dates that you received treatment, department in which you received treatment, name of your treating physician, and certain information about the outcome of your treatment to contact you for fundraising purposes.

You have the right to opt out of receiving fundraising communications at any time. If you wish to be removed from future CUMC fundraising communications, please contact the CUMC Privacy Office by telephone (212-305-7315) or e-mail (HIPAA@columbia.edu).

Individuals Involved in Your Care or Payment for Your Care
We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research
Under certain circumstances, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Before we use or disclose Health Information for research, however, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for similar purposes, so long as they do not remove or take a copy of any Health Information.

As Required by Law
We will disclose medical information about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety
We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.

Business Associates
We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation
If you are an organ or tissue donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation
We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose Health Information for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make such disclosure.

Health Oversight Activities
We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may release Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities and Protective Services
We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We also may disclose Health Information to authorized federal officials so they may conduct special investigations and provide protection to the President, other authorized persons and foreign heads of state.

Coroners, Medical Examiners and Funeral Directors
We may release Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

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 information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact the Privacy Officer for more information about these protections.

Other Uses of Health Information
Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. For example, except for limited circumstances allowed by federal privacy law, we will not use or disclose psychotherapy notes about you, sell your health information to others, or use or disclose your health information for certain promotional communications that are considered marketing under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may revoke your authorization at any time by submitting a written request to our Privacy Officer, except to the extent that we acted in reliance on your authorization.

Your Rights Regarding Health Information About You
You have the following rights, subject to certain limitations, regarding Health Information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. If we maintain a copy of your Health Information electronically, you also have the right to obtain a copy of that information in electronic format. You can also request that we provide a copy of your information to a third party that you identify. We may deny your request to inspect or copy your medial information in limited circumstances. If we deny you request, you have the right to have the denial reviewed. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments
If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by or for Columbia. A request for amendments must be submitted, in writing, to the Privacy Officer at the address provided at the end of this notice. We may deny your request for an amendment in limited circumstances. If we deny you request, you may have a statement of disagreement added to your Health Information.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures" of Health Information. This is a list of certain disclosures we made of Health Information in the six years prior to your request. We are not required to account

for certain disclosures including disclosures for treatment, payment or health care operations or disclosures to you or pursuant to your authorization. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions
You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Be Notified of a Breach
You have the right to be notified if a breach occurs that may have compromised the privacy or security of your Health Information.

Right to Restrict Certain Disclosures to your Health Plan
You have the right to request that we not disclose Health Information to your health plan if that information relates to health care items or services for which you have paid out of pocket, in full, at the time that the service is provided. You must notify the practice of your request to not provide Health Information about the service to your health insurance plan. We will agree to such requests unless required by law to disclose that information to the health plan

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our web site, http://www.cumc.columbia.edu/hipaa/

How to Exercise Your Rights
To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. Alternatively, to exercise your right to inspect and copy Health Information, you may contact your physician's office directly. To obtain a paper copy of our Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current Notice at each Columbia physician office or outpatient location and on our website. The end of our Notice will contain the Notice's effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with Columbia or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Columbia, contact our Privacy Officer at the address listed at the end of this notice. You will not be penalized for filing a complaint.

Questions
If you have a question about this Privacy Notice, please contact:

Privacy Officer
Office for HIPAA Compliance
Columbia University Medical Center
630 West 168th Street, Box 159 New York, NY 10032

Phone: 212-305-7315

Effective date: September 23, 2013
E-mail: hipaa@columbia.edu
Website: www.cumc.columbia.edu/hipaa