Columbia Orthopaedic Surgery
PATIENT DEMOGRAPHIC INFORMATION

DR._____ MRN:_____

LAST NAME EPSTEIN FIRST JEFFREY MI E AGE 59 SEX (M) / F
ADDRESS 9 EAST 71ST ST, NY, NY 10021 APT.#_____
CITY/STATE NY, NY ZIP CODE 10021
HOME PHONE [redacted]
CELL PHONE [redacted] EMAIL ADDRESS jeevacation@gmail.com
MAIDEN NAME_____ MOTHER'S FIRST NAME PAULA
DATE OF BIRTH [redacted] FATHER'S FIRST NAME SEYMOUR
EMPLOYER FTC (FINANCIAL TRUST CORP) BUSINESS PHONE [redacted]
EMPLOYER'S ADDRESS 6100 RED HOOK QUARTERS, B-3, ST. THOMAS, USVI 00802

EMERGENCY CONTACT

NAME [redacted] RELATIONSHIP TO PATIENT FRIEND
ADDRESS [redacted]
HOME PHONE [redacted] WORK PHONE [redacted]

INSURANCE INFORMATION

PRIMARY INSURANCE NAME UNITED HEALTHCARE
ADDRESS OF INS. COMP. PO BOX 740800, ATLANTA, GA 30374-0800
TEL# OF INS. COMP. 877-842-3210 CONTACT PERSON_____
ID# [redacted] GROUP/POLICY# [redacted]
NAME OF POLICY HOLDER JEFFREY EPSTEIN
PATIENT'S RELATIONSHIP TO POLICY HOLDER SELF
EMPLOYER OF POLICY HOLDER FINANCIAL TRUST CO. (FTC)
EMPLOYER'S ADDRESS/PHONE 6100 RED HOOK QUARTERS, B-3, ST. THOMAS, USVI 00802

SECONDARY INSURANCE NAME_____
ADDRESS OF INS. COMP._____
TEL# OF INS. COMP._____ CONTACT PERSON_____
ID#_____ GROUP/POLICY#_____
NAME OF POLICY HOLDER_____
PATIENT'S RELATIONSHIP TO POLICY HOLDER_____
EMPLOYER OF POLICY HOLDER_____
EMPLOYER'S ADDRESS/PHONE_____

NO FAULT CASE INFORMATION

ACCIDENT DATE/TIME_____ CLAIM/FILE#_____ PHONE_____
INSURANCE NAME_____ CONTACT PERSON_____
ADDRESS_____

WORKER'S COMPENSATION INFORMATION

ACCIDENT DATE/TIME_____ CLAIM/FILE#_____ PHONE_____
INSURANCE NAME_____ CONTACT PERSON_____
ADDRESS_____

Orthopaedic Clinical Intake Form

MRN: _____

Today's Date: APRIL 13, 2012

Name: JEFFREY EPSTEIN Age: 59 Date of Birth: [redacted]

Gender: MALE Height _____ Weight: _____ Preferred Language: ENGLISH

Referring Physician: DR. MOSKOWIZ Phone: [redacted]

Address: [redacted]

Primary Care Doctor: SAME Phone: _____

Address: _____

Pharmacy Name: CLYDE'S PHARMECY Phone: [redacted]

Address: 926 MADISON AVE (CORNER @ 74TH : MADISON)

What is the reason for your visit today? _____

Location of pain (include side): _____ **Are you right or left hand dominant?** _____

How long has it been present? _____ **Describe pain:** dull_____ sharp_____ tingling_____ other_____

When does pain occur? at rest _____ with activity _____ at night _____ other _____

Any other symptoms associated with current problem? _____

Severity: on a scale from 1-10, indicate how severe the pain is on the scale below with 1 being very little pain to 10 being excruciating/can't function (circle number): 1 2 3 4 5 6 7 8 9 10

Indicate what makes it better? pain medicine_____ ice_____ heat_____ rest_____ elevation_____

Context: How did it occur? _____

If result of injury, date occurred _____ Is it better? _____ Is it worse? _____

PAST MEDICAL HISTORY: Please list past medical conditions below

Asthma	___No	___Yes	DVT/PE (Blood Clot)	___No	___Yes
Blood or plasma transfusions	___No	___Yes	Heart Disease	___No	___Yes
Cancer	___No	___Yes	Lung disorder	___No	___Yes
Cholesterol	___No	___Yes	Stomach/Intestinal disorder	___No	___Yes
Clotting disorder	___No	___Yes	Thyroid problems	___No	___Yes
Diabetes	___No	___Yes			
Hypertension	___No	___Yes	*Other:* _____		

PAST SURGICAL HISTORY: Please list any surgeries you have had:

Type of Surgery	Approx. Date	Complications if any

Have you ever had general anesthesia? _____

Have you had any problems with anesthesia? _____ **Describe:** _____

Orthopaedic Clinical Intake Form

MRN: _____

Name: JEFFREY EPSTEIN Date of Birth: [redacted]

MEDICATIONS, VITAMINS, SUPPLEMENTS & HERBS: Please list all medications, vitamins, supplements and herbs you are currently taking including dosage in the lines below:

Name	Dosage/Amount

ALLERGIES: Please list allergies and reaction or write "NONE"(include medications, environmental agents, food, other)

Allergy	Reaction	Allergy	Reaction

SOCIAL HISTORY:

Occupation: BANKER Marital Status: S

Home: 1 story ____ 2 story + entrance steps Y apartment ____ elevator Y

Do you exercise regularly? ____ Involved in school sports? ____

Are you a tobacco user? No Cigarettes? ____ Cigars? ____ Smokeless Tobacco? ____ Other?_____

Average per day? ____ # of years?____ If no, have you ever? ____

Do you currently consume alcohol? No Average # per wk? ____ If no, have you previously? ____

Do you currently use drugs? No

FAMILY HISTORY: Please indicate any major conditions/illnesses for family members below.

Relative	Alive (age)	Deceased (age)	Cause of Death	Health Problems
Mother				
Father				
Siblings				
Other				

Orthopaedic Clinical Intake Form

MRN:_____

Name: JEFFREY EPSTEIN Date of Birth: [redacted]

REVIEW OF SYSTEMS:

Are you currently having or have you had problems with your:

(If yes, check box to right of symptoms that apply)

Constitutional	No / Yes	Fatigue☐ Headache☐ Fever☐ Weight Loss☐ Other:_____
Eyes	No / Yes	Glasses☐ Blurred vision☐ Other: _____
Ears,Nose,Throat	No / Yes	Congestion☐ Hearing Loss☐ Jaw discomfort☐ Other:_____
Lungs, Breathing	No / Yes	Cough☐ Wheezing☐ Shortness of breath☐ Other:_____
Heart	No / Yes	Heart murmurs☐ Irregular heartbeat☐ Other:_____
Gastrointestinal	No / Yes	Nausea☐ Vomiting☐ Stomach aches☐ Constipation☐ Diarrhea☐ Other:_____
Bladder	No / Yes	Incontinence☐ Urinary tract infections☐ Difficulty urinating☐ Other:_____
Endocrine	No / Yes	Diabetes☐ Thyroid problems☐ Delays in growth☐ Other:_____
Musculoskeletal	No / Yes	Joint pain☐ Leg pain☐ History of broken bones☐ Other:
Bleeding	No / Yes	Anemia☐ Prolonged Bleeding after cut/injury☐ Other:_____
Neurological	No / Yes	Dizziness☐ Numbness/tingling☐ Headaches☐ Frequent falls☐ Other:_____
Integumentary	No / Yes	Rashes☐ Skin Disorders☐ Connective tissue disorders☐ Other:_____
Psychiatric	No / Yes	Change in mood or behavior☐ Change in sleep patterns☐ Other:_____
Immunologic/ Allergic	No / Yes	Asthma☐ Hay fever☐ Chronic rashes☐ Communicable Diseases☐ Other:_____

_____ _____

Signature (Person Completing Form) Date Completed

_____ _____

Physician Signature Date

FOR OFFICE USE ONLY: Initials below indicate **Allergies**, **Medications**, and **Problems** have been data entered as discrete elements into the CROWN System.

_____
_____
Initials

Additionally, the indicated elements of Section #1 have been data entered into the CROWN System as discrete data:

___ Family History ___ Past Medical History
___ Past Surgical History ___ Social History

Orthopaedic Clinical Intake Form

MRN: _____

Name: JEFFREY EPSTEIN Date of Birth: [redacted]

WORKER'S COMPENSATION & NO FAULT

If this problem is related to a work or car Accident, please complete the following questions:

Work related?_____ Car accident related?_____ Date of accident/onset _____

Which part(s) of your body was injured (include side)? _____

Prior to this accident, did you have a problem/pain in the affected area? _____

Did you sustain other injuries due to this accident? _____ If yes, please give details (ex: left hand laceration):

_____

Did you have immediate pain of the affected area at the time of the accident or a few days later? _____

Where (address with state) and how did the injury occur? _____

_____

Job title on date of injury _____

What were your usual work activities on the date of the injury/onset? _____

Employer when injury occurred (include address and phone #):_____

Have you been treated by another health care provider for this injury? If so, give details _____

_____

Are you currently working? _____ If Yes, regular or modified duties (if modified, give details)? _____

_____

If you are Not working, what is the date you first missed work due to this injury? _____

Are you being counseled by a lawyer for this injury? _____

If car accident, where you the driver or passenger? _____

Did the air bag deploy? _____ Where you wearing your seat belt at the time of the accident? _____

_____ _____

Signature (Person Completing Form) Date Completed

New York Orthopaedic Hospital Associates

Christopher S. Ahmad, M.D.
Louis U. Bigliani, M.D.
Edwin R. Cadet, MD.
Jeffrey A. Geller, M.D.
Justin K. Greisberg, M.D.
Joshua E. Hyman, M.D.
YongJung Kim, M.D.
Francis Y. Lee, M.D.
Jonathan Lee, MD.
William N. Levine, M.D.
William B. Macaulay, M.D.
Christopher B. Michelsen, M.D.
Ohannes A. Nercessian, M.D.
Melvin P. Rosenwasser, M.D.
Benjamin D. Roye, M.D.
David P. Roye, M.D.
Robert J. Strauch, M.D.
Peter Tang, M.D.
J. Turner Vosseller, M.D.
Michael G. Vitale,M.D.
Mark Weidenbaum, M.D.
Nicole Baiton, NP.
Carmela Evangelista, NP
Rachael Lyons, DPN

Date: APRIL 13, 2012

Patient Name: JEFFREY EPSTEIN **DOB:** [redacted] **MRN:** _____

Thank you for choosing the New York Orthopaedic Hospital Associates (NYOHA). We are committed to the success of your medical treatment and care. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing. Because of this, we have outlined our practice's policy in detail. If you have any questions about our policies, our staff is happy to assist you.

What Is My Financial Responsibility?

Your financial responsibility depends on a variety of factors, explained below. Please check off which insurance type applies to the patient.

Patient Payment Policy
Payment for Office Visits and Services

If You Have...	You Are Responsible For...	NYOHA Will...
☐ **Commercial insurance** Also known as indemnity, or "regular" insurance.	Paying for services at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
☐ **Managed care plans with which NYOHA has a contract**	Obtaining referral authorization from your primary care physician if needed Paying your deductible, copay, and any services that are not covered by your plan, at the time of your visit.	Inform you of any services not covered by your plan. File the insurance claim.
☐ **Out of network PPO or HMO plans**	Paying your deductible and full charges at the time of the visit.	File the insurance claim.
☐ **Regular Medicare**	Paying your deductible if it is not yet met, as well as any services not covered by Medicare. If you do not have secondary coverage or Medigap, you will also be asked to pay the 20% Medicare coinsurance.	File the Medicare claim, as well as any claims to your secondary insurance.
☐ **Medicaid**	Obtaining a referral authorization from your primary care physician as needed. No payment is due at the time of service.	File the Medicaid claim.
☐ **Worker's Compensation**	If you supply our staff with a valid case number, adjuster name and phone number, no payment is necessary at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
☐ **Uninsured or Major Medical only**	Paying for services at the time of the visit.	Work with you to settle your account.
☐ **Third Party Liability and Accident Victims**	Paying for services at the time of the visit.	File the claim, according to the rules stated by your primary insurance carrier.
☐ **Personal Injury**	Payment for services at the time of the visit.	Cooperate with your attorney to provide copies of records and reports. (At an additional charge.)

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Columbia University Health Sciences Notice of Privacy Practices.

JEFFREY EPSTEIN	APRIL 13, 2012
Patient Name	Date
Signature of patient or personal representative	If personal representative, Personal representative's authority to act

Scan Folder: Hipaa

Revised 06/29/2011

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

The Federal Government requires us to ask these questions. This information is used to track illnesses by age, gender, race and ethnicity. We will also use this information to identify the needs of different patient groups and develop plans to address them and monitor the quality of our services for all patients so everyone gets the highest quality care regardless of their racial or ethnic background. We ask that you check one box under each category and thank you for taking the time to complete this information.

Name: JEFFREY EPSTEIN **Date of Birth:** [redacted]

MRN#: _____ **Visit Date:** APRIL 13, 2012

Ethnicity:

- ☐ Decline Response (I do not wish to answer)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response (I do not wish to answer)
- ☐ American- Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other

Preferred Language:

- ☐ Decline Response (I do not wish to answer)
- ☐ ARABIC
- ☐ CHINESE
- ☐ CZECH
- ☐ DUTCH
- ☐ ENGLISH
- ☐ FRENCH
- ☐ GERMAN
- ☐ GREEK
- ☐ HEBREW
- ☐ HINDI
- ☐ INDONESIAN
- ☐ ITALIAN
- ☐ JAPANESE
- ☐ KOREAN
- ☐ MALAY
- ☐ Other
- ☐ PERSIAN
- ☐ POLISH
- ☐ PORTUGUESE
- ☐ ROMANIAN
- ☐ RUSSIAN
- ☐ SIGN LANGUAGE
- ☐ SLOVAK
- ☐ SPANISH
- ☐ SWAHILI
- ☐ TAGALOG
- ☐ THAI
- ☐ TURKISH
- ☐ URDU
- ☐ VIETNAMESE
- ☐ YIDDISH

DO NOT SCAN THIS DOCUMENT

MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to
(Print patient's name)

_____, ("Assignee") all rights privileges and remedies to payment
(Print provider's name)
for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other
(Date of accident)
agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of Signature)

_____
(Address of Patient)

_____
(Print name of Provider)

_____

_____
(Provider Address)

FINANCIAL TRUST COMPANY
6100 RED HOOK QUARTER, B-3
ST THOMAS VI 00802-0000

UnitedHealthcare

>000343 7344480 001 003082
J.EPSTEIN
6100 RED HOOK QUARTER B-3
ST THOMAS VI 00802-0000

03082 7344480 0000 0000343 0000343 020 4 111

UnitedHealthcare

Health Plan (80840) [redacted]

Member ID: [redacted]

Group Number: [redacted]

Member:
JEFFREY EPSTEIN

FINANCIAL TRUST COMPANY

Payer ID [redacted]

medco
Rx Bin:
Rx Grp: [redacted]

Office: $20 ER: $200
UrgCare: $75 Spec: $30

DOI - 0501

UnitedHealthcare Choice Plus
Underwritten by UnitedHealthcare Insurance Company

Printed: 10/27/09

[redacted]

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: www.myuhc.com
Care24:
Mental Health: [redacted]

For Providers: www.unitedhealthcareonline.com
Medical Claims: P.O. BOX 740800 ATLANTA GA 303740800

V.I. Equicare, Inc.

shared savings
MultiPlan

Pharmacy Claims:PO BOX 14711, LEXINGTON KY 40512
For Pharmacists: 800-922-1557

Advanced Cardiovascular Imaging
62 East 88th St
New York, NY 10128

Phone [redacted] FAX [redacted]

Steven D. Wolff, M.D., Ph.D
Director

Rony Shimony
110 E 59 St
Ste 8A
New York, NY 10022

Patient Name: EPSTEIN, JEFFREY
DOB: 01/20/1953
Exam Completed: 09/22/2011 5:55 PM

ACC: [redacted]
MRN: [redacted]

Examination

LUMBAR SPINE MRI

Comparison
None available

Clinical History

Pain in back and legs

Technique

Sagittal FSE, Axial FSE, Sagittal FLAIR T1, Sagittal IR

Findings

There is minimal degenerative grade 1 anterolisthesis of L4 on L5. Conus ends normally at the lower T12 level and appears intrinsically normal. There is no acute fracture.
T11-T12-L2-L3 there is no focal disc herniation or stenosis.
L3-L4, there is disc bulge and facet arthrosis.
L4-L5, there is anterolisthesis, there is broad disc bulge with facet arthrosis and ligamentum flavum hypertrophy. There is severe central canal, subarticular and moderate to marked foraminal stenosis. There is impingement of the L5 and encroachment on the exiting L4 nerves.
L5-S1 there is disc bulge asymmetric to the right with right greater than left facet arthrosis. There is mild to moderate right subarticular stenosis with encroachment on the right S1 nerve.

Impression
Severe L4-L5 and to a lesser degree right-sided L5-S1 stenosis.

Thank you for the courtesy of this referral.

Dictated by: Jilani, Mohammad MD
Electronically Signed By: Jilani, Mohammad, MD 09/23/2011 9:14 AM
Transcribed by: Jilani, Mohammad, MD on September 23, 2011 9:14 AM

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

Department of Orthopaedic Surgery
Appointment Scheduling Department
Tel. [redacted]

April 03, 2012

Jeffrey Epstein
301 East 66th Street
Suite 10b
Palm Beach, FL 10065

Re: EPSTEIN,JEFFREY MRN: IDX00938430

We are proud to welcome you as a new patient of Mark Weidenbaum, MD. You can feel confident in knowing you are now in the care of one of the top doctors in the nation. His reputation has helped our medical center remain ranked as a leader in orthopedics.

Your appointment is scheduled for:
04/13/2012 11:45AM For your consultation with Mark Weidenbaum, MD.
Please arrive one hour earlier if you are scheduled for an x-ray.
161 Ft. Washington Avenue 2nd Fl
New York, NY
(*Directions are enclosed.*)

To ensure your first visit with us meets your expectations, we have provided a checklist of items to help you prepare. We have also enclosed documents for you to complete at your convenience and bring with you.

Check list:

☐ **Patient Demographic Information**: Please complete and sign. Please make sure you have included your referring physician and/or primary care physician(s) contact information, so we can coordinate your care. *If you need assistance with completing any part of the enclosed forms, our staff will be happy to help you on the day of your appointment.*

☐ **Medical History**

- Medical History Form. Please complete and sign.
- Copies of relevant medical records including all surgical reports and test results.
- Radiological films and reports such as x-rays, MRI or CT scan, etc.
- Medications you are currently taking. **(Please bring actual bottles or containers)**

☐ **Payment Information**: ***Payment is due at the time of your visit.***

- Patient Payment Policy is enclosed for you to review and sign.
- Please bring your Insurance card(s).
- **Insurance referral if applicable**. *If you are on a managed care plan with which our doctor participates, please ensure that you obtain necessary referrals.* ***Patients are responsible for payment in full if referrals are not received by the time of the visit.***
- Payment can be made using cash, check or credit card.
- Charges for ancillary testing such as laboratory, radiology and other tests may be billed to you separately.

☐ **Notice of Privacy:** ****Note if you have previously signed a notice of Privacy for any Columbia NYPH Provider you will not have to sign a new one.***

- Please sign and return the **Patient Acknowledgment of the Notice of Privacy Practices.**

We look forward to your visit and providing you with the care you deserve. We understand busy schedules, so if you need to cancel or reschedule your appointment please let us know 24 hours prior to your appointment. This will allow us to reschedule at your convenience, and provide a patient on our waiting list with the same opportunity. Please call our office at (212) 305-4565.

Sincerely,
Pre-Appointment Scheduling Department
Columbia Orthopaedics
Columbia University Medical Center

Herbert "Irving" Pavilion
161 Fort Washington Avenue, 2nd Fl
New York, NY 10032
Between Riverside Drive and Broadway
Corner of 165th St. and Fort Washington Ave.

From George Washington Bridge:1
Exit onto Henry Hudson Parkway, and then onto the Riverside Drive South. Continue on Riverside Drive until 165th Street. Make left onto 165th Street. Go up 1 block to Fort Washington Avenue. Make left to Herbert Irving Pavilion or make right to parking garage and then walk to Herbert Irving Pavilion.

From Saw Mill River Parkway:
Exit the Henry Hudson Parkway at the Riverside Drive exit. See directions from Riverside Drive above.

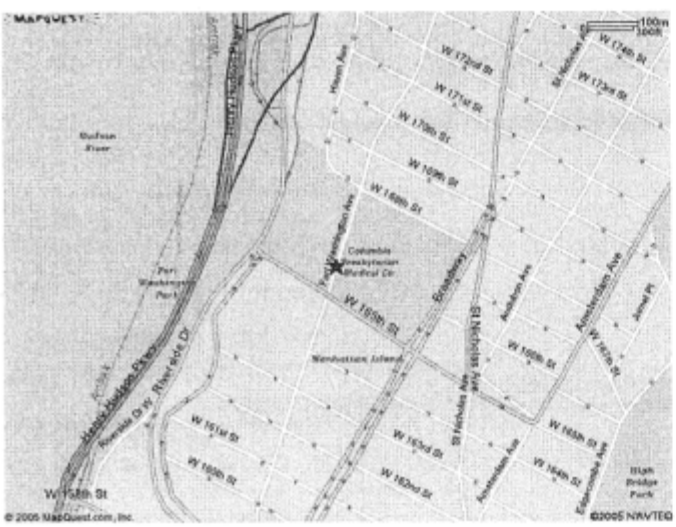
From Westchester, Connecticut, and the East Side of Manhattan via major Deegan, Cross Bronx Expressway or Harlem River Drive:
Approaching the George Washington Bridge, take the Henry Hudson Parkway exit, stay on the left and follow signs to Broadway. Make left onto Broadway. Continue on Broadway until West 165th Street. Make right onto West 165th Street. Continue one block to Fort Washington Avenue. Make right onto Fort Washington Avenue to Herbert Irving Pavilion or make left to parking garage and then walk to Herbert Irving Pavilion.

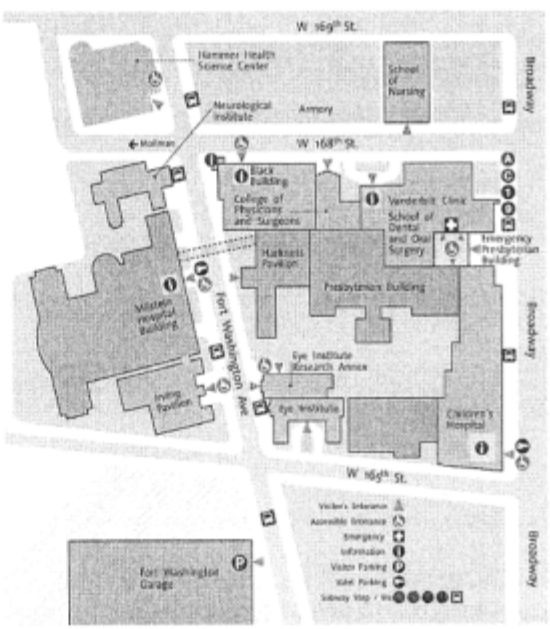
From West Side of Manhattan:
Take Henry Hudson Parkway to exit 15-Riverside Drive South. Follow directions from Riverside Drive South above.

Public Transportation:
Via subway- A, C, 1 or 9 train to 168th Street and Broadway. Bus - M2, M3, M4, M5, M100, or BX7

Parking: Parking is available at the corner of 165th Street and Fort Washington. Valet Parking is available at the Milstein Hospital Building next door.

Radiology: If you are scheduled for an x-ray, you should report to our 2nd floor reception desk to pick up the requisition before proceeding to the Radiology Department on the 1st floor.

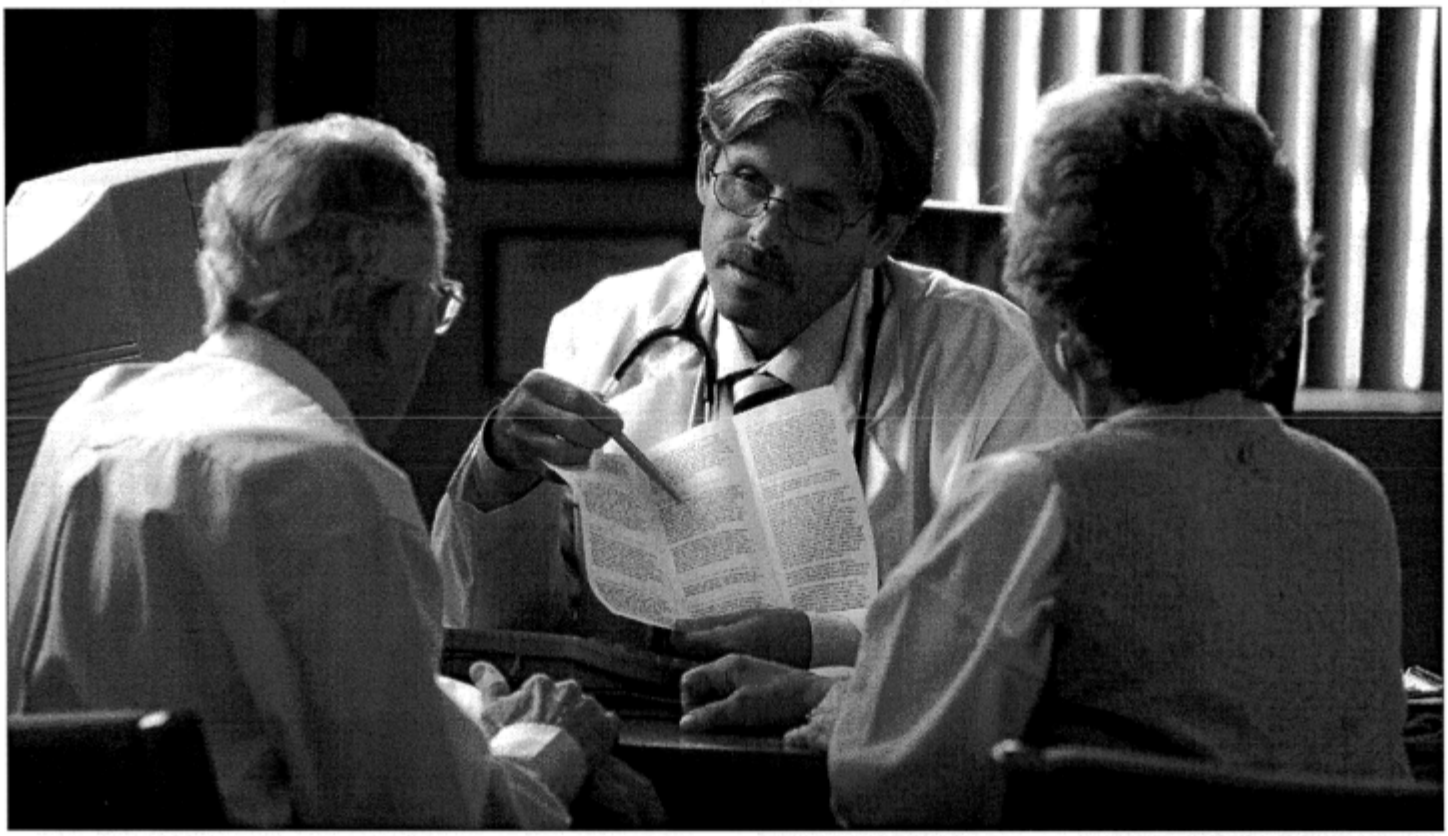




Notice of Privacy Practices

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.

COLUMBIA UNIVERSITY MEDICAL CENTER



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 ("Columbia University", "Columbia", "we" or "us"), including its employed faculty physicians and faculty physicians practicing on Columbia University owned or leased space, as well as their clinical support staff. This Notice also covers Columbia University Health Care, Inc.; the Ophthalmology Faculty Practice Corporation; Orthopedics, P.C.; Neurosurgery, P.C.; and Urology, P.C. (all "Columbia University"). 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

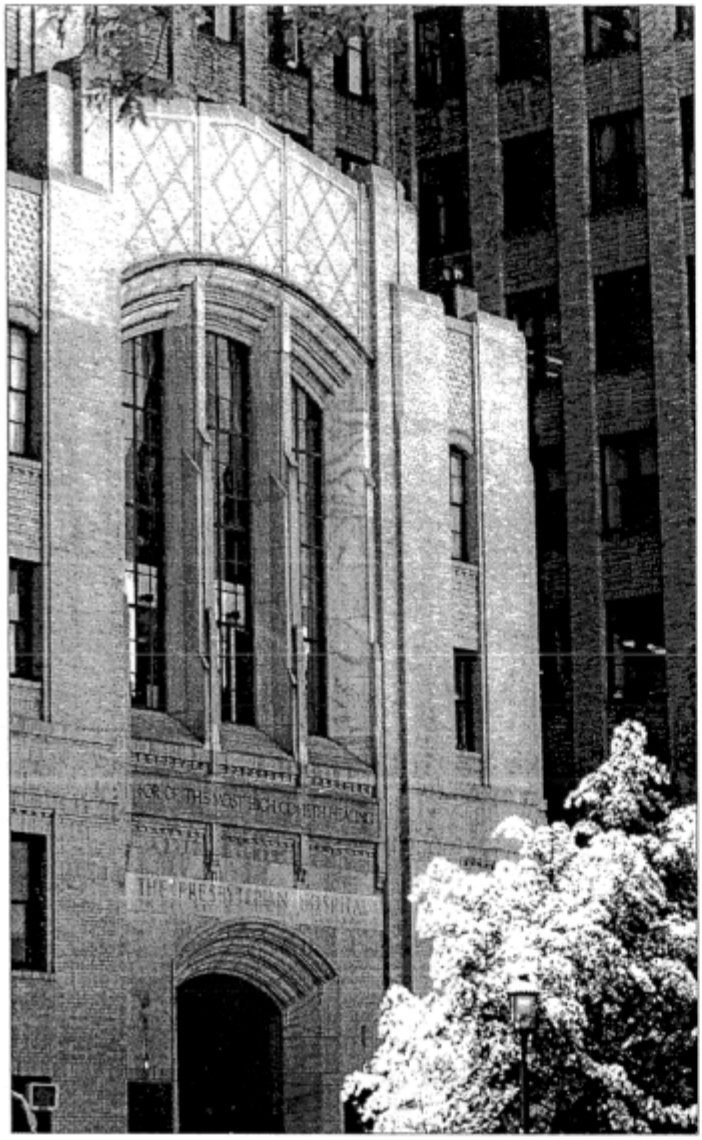
The following categories describe different ways that we may use and disclose Health Information.

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

We may use your demographic information to contact you in an effort to raise money for Columbia. Any fundraising letter you receive from us will provide you with instructions on how to opt out of any future fundraising letters. We will not use your diagnosis to fundraise unless you authorize us to do so in writing.

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 if 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 the 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 permission. You may revoke your permission at any time by submitting a written request to our Privacy Officer, except to the extent that we acted in reliance on your permission.

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. 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.

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. 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 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

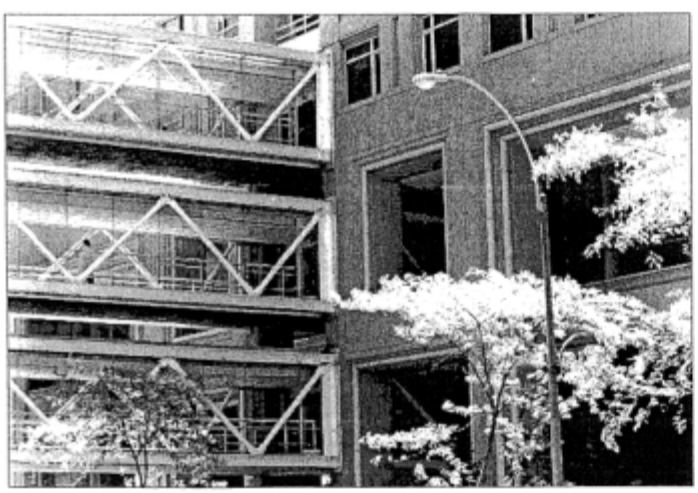
To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. Alternatively, to exercise your right to inspect and copy Health Information, you may contact your physician's office directly. To obtain a paper copy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



Columbia University Medical Center

Questions

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

Privacy Officer
Office for HIPAA Compliance

Columbia University Medical Center
601 West 168th Street
Apartment 22
New York, NY 10032
Phone: [redacted]
E-mail: [redacted]
Website: www.cumc.columbia.edu/hipaa

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