

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 medical information in limited circumstances. If we deny your 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 your 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



Important Information About Patient Email

As a patient at Columbia University Medical Center, you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via email and how Columbia University Medical Center will use and disclose provider / patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider / patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider / patient email is not available to you - and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and / or your phone have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email messages may be inadvertently missed. To minimize this risk, Columbia University Medical Center requires you respond appropriately to a test email message before we will allow health information about you to be communicated via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with your providers or program.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, individuals at Columbia University Medical Center other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.



Patient Request for Email Communications

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email. To request that this provider/program communicate with you via email you must complete this form and return it to your health care provider's office.

Please be advised that:

- (1) **This request applies only to the healthcare provider or program that you indicate below. If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.**
- (2) Columbia University Medical Center will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via email.
- (3) Your request will not be effective until you receive and respond appropriately to a test email message.

Please select the question you want to use (by checking one of the boxes below) for your test email and provide your answer.

- My mother's maiden name: _____
- My middle name: _____
- The street number of my residence: _____

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated this way.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Columbia University Medical Center and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature of patient or personal representative

Date

If personal representative, authority to act on behalf of patient

Name of Physician or Program



Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information:

- Office Notes /Name of Physician. _____
 Pathology Reports Radiology Reports Laboratory Reports Date(s): _____
 Other: _____

The purpose for this request to release medical information is:

- Medical Care / Treatment Insurance Other (specify) _____

Send my medical information to: Name: _____
Address: _____
City, State, Zip: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional NYSDOH HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- CUMC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment. (can remove)
- This Authorization expires on ____ / ____ / ____ {if date not completed / one year after signed}

Patient / Representative Signature

Date

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

Print Name

Relationship to patient

Retain this form in the patient's medical record and provide a copy to the patient.

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

Patient Name: _____

MRN # _____

Date: _____

Thank you for choosing the Department of Neurology at Columbia University Medical Center. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing so we have outlined our practice's policy. If you have any questions about our policies, our staff will be 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.*

Payment for Office Visits and Services

(1) If You Have...	(2) You Are Responsible For...	(3) We Will...
<input type="checkbox"/> Managed Care or Commercial Indemnity insurance plan and the provider is <u>not</u> a participating provider or benefits are considered out-of-network.	Paying 100% of the provider's full charges.	Submit an insurance claim to your insurance carrier on your behalf.
<input type="checkbox"/> Managed care plan and the physician <u>is</u> a participating provider or benefits are considered in-network	Obtaining referral authorization, if applicable Paying your deductible, copayments and any other financial obligation as stated in your plan	Inform you of any services not covered by your plan. Submit an insurance claim to your insurance carrier
<input type="checkbox"/> Traditional Medicare	Paying your deductible if it is not yet met for the calendar year, 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.	Submit the Medicare claim, as well as any claims to your secondary insurance. For services that may not be covered by Medicare provide you with a Medicare ABN or Waiver for signature.
<input type="checkbox"/> Traditional Medicaid	Area Specific: Generally, you are responsible for no payment when the physician's office accepts Medicaid. If Medicaid is not accepted, you may be responsible for the visit charge upfront.	If Medicaid is accepted in your physician's office, we will bill Medicaid. If Medicaid is not accepted, we will collect the visit charge upfront.
<input type="checkbox"/> Worker's Compensation or No Fault	Providing to our staff a valid case number, accident date, insurance name and address, adjuster name and phone number. Providing authorization for the service if needed. Providing an AOB form for your No Fault carrier. No payment is due at the time of service.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
<input type="checkbox"/> Uninsured	Paying 100% of the provider's full charges	Work with you to settle your account.

Patients Who Are Minors

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

Agreement Confirmation

I have read, understand, and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductible are my responsibility and are payable immediately upon receipt of patient statement.

I authorize my insurance benefits be paid directly to the Department of Neurology. I authorize the Department of Neurology at Columbia University Medical Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

 Patient or Guarantor Printed Name

 Patient or Guarantor Signature

 Date



**AUTHORIZATION FOR USE AND DISCLOSURE OF LIMITED HEALTH INFORMATION
For FUNDRAISING PURPOSES**

Columbia University Medical Center (CUMC) relies upon the generosity of our patients to help us remain at the forefront of patient care, research and education. Federal law requires health care providers to obtain your written authorization prior to contacting you about our philanthropic initiatives that support the work of our doctors, and so we now seek your permission to do so. As maintaining patient confidentiality and ensuring your right to privacy remains our highest priority, be assured that your diagnosis or treatment information will not be disclosed without your permission.

We ask that you take a moment to review the authorization and sign below. If you have any questions please call the CUMC Office of Development at (212) 304-7200.

I authorize CUMC to use the **department or program where I am receiving healthcare services and/or the name of my physician** to contact me about information related to my personal health needs and interests, including:

- *New Scientific Advances*
- *Patient Care Programs And Service Enhancements*
- *Community Activities, Presentations, Events, and Health Forums*
- *Opportunities To Support Columbia University Medical Center*

This authorization allows us to personalize our communication to you as we seek to keep you informed about relevant health information and activities at Columbia University Medical Center.

Only your physician, the Office of Development at CUMC or its Business Associates will use this information to discuss or send you information about fundraising opportunities at CUMC.

Failure to sign this authorization will not affect your treatment, payment, or eligibility for benefits in any way and I understand that signing this form it is voluntary.

Information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal or state law.

This authorization is valid until revoked by the patient or their authorized representative. You may revoke this authorization at any time or request to inspect or receive a copy of the protected health information to be used or disclosed by submitting a request in writing to: Office of Development 100 Haven Ave, Suite 29D, N.Y. N.Y. 10032. The revocation will be effective immediately except to the extent that we have already relied on your authorization.

This authorization will expire in 20 years and you have the right to a copy of the signed authorization.

NAME OF PATIENT: _____ **DATE:** _____

SIGNATURE: _____

ADDRESS: _____

Relationship if someone other than the patient (e.g. parent) _____

NAME OF PHYSICIAN / DEPARTMENT / PROGRAM _____