COLUMBIA UNIVERSITY DEPARTMENT OF PSYCHIATRY
PATIENT FINANCIAL AGREEMENT

I_____ (Patient Name) acknowledge the payment and insurance information set form below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the programs and physicians and other health care providers affiliated with the Columbia University, Department of Psychiatry, and Columbia physicians from other medical specialties asked to consult on my care by the psychiatric treatment team.

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I know that I may request and will receive a written fee schedule. Columbia may change its fees in the future. Insurance coverage may not pay for all my services. In some instances, payment will be solely my responsibility. I understand that:

    - Payment for regular outpatient service is due at the time of treatment. NOTE: I will be charged for outpatient appointments I do not keep, unless I cancel the appointment at least 24 hours in advance. I understand that I cannot submit bills for cancellations to my insurance company or managed care plan.
    - Payment for day treatment must have a credit card on file otherwise; a month in advance check is required based on my treatment plan.
    - Bills for inpatient treatment are sent after discharge. However, if I do not have insurance coverage for inpatient treatment I will have to pay in advance for the expected length of my stay in the hospital. Columbia will refund overpayments within 6-8 weeks.
    - Columbia offers a package of Enhanced Services for inpatient stays. This package is not covered by insurance. The price for these Enhanced Services is $_____ a day. If I choose to purchase this package, payment will be my responsibility. The Enhanced Services package consists of one or more professional services, per day, and may include: individual and/or family counseling with a clinical psychologist, individual substance abuse therapy and cognitive-behavioral therapy.

2. Insurance and Managed Care Plans: Columbia participates in a number of insurance and managed care plans. If Columbia participates in my plan, I agree to pay all applicable charges, deductibles, co-payments, co-insurances. If Columbia does not participate in my insurance plan, Columbia may, at its discretion, accept assignment from my plan. If Columbia accepts such assignment, I agree to pay any charges, deductibles and co-payments required by my plan. If my insurance benefits run out, Columbia will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage.

3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care: I agree to allow my insurance plan or managed care plan to pay Columbia directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Columbia unless I have already paid the charges myself.

    I authorize Columbia to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Columbia to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

4. I have signed a HIPAA [patient privacy laws and regulations] acknowledgment with the Department.

5. I understand Columbia may release me as a patient if I do not adhere to this agreement. If this happens, Columbia will assist me in making alternative arrangements for my treatment, if necessary.

6. Name of responsible party: _____Rel. to patient: _____

    Signature: _____Telephone: Work_____Home_____

    Address of responsible party: _____

    Date: _____ Witnessed by for Columbia: name: _____signature:_____

7. Credit Card Authorization for co-payments and fees by faculty physicians and providers of Columbia University

    Circle one: *Visa MasterCard Amex Discover* Account No: _____Exp._____

    Signature: _____Date:_____

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New Patient Demographic Form

*Date:*_____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: _____

Home Address: _____ Apt: _____

City, ST: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Preferred: Home Other

Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____/____/____

Address: _____ City, ST: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Emergency Contact (if other than guarantor): _____

Emergency Phone: _____ Relationship to Patient: _____

Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City, ST: _____ ZIP: _____

Certificate/Plan/ID #: _____ Group (Grp): _____

Subscriber (if other than patient or guarantor): _____

Subscriber Address: _____ City, ST: _____ ZIP: _____

Subscriber Date of Birth: ____/____/____ Relationship to Patient: _____

Please present a copy of your insurance card/information, if available, when you return this form.

Patient Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City, ST: _____ Zip: _____

Patient Work Phone: _____

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

☐ Send me an invitation to join myColumbiaDoctors.
Look for your email invite to register from noreply@followmyhealth.org and click the registration link.

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Last Name: _____ First Name: _____ DOB: / /

Please provide information regarding your health care providers in the spaces below:

	Name	Phone	Location	Date of last visit
Primary Care				/ /
Psychiatrist				/ /
Psychotherapist				/ /
Dentist				/ /

Preferred Pharmacy: _____ Pharmacy Phone: _____

Preferred Pharmacy Address: _____

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 may be collected upon check-in for each visit. 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.

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: _____

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Answers to the all questions in this packet are for our records only and are confidential. No outsider, not even your closest relative or family doctor, is permitted to see your case record without your written permission.

SECTION II

1. Do you have any allergies to medications or other substances? **Y / N**
   a. If so, please list allergies and reactions: _____
   _____
2. Do you have any significant medical problems? **Y / N**
   a. If so please list any: _____
3. Are you receiving any medication for these problems? **Y / N**
   a. If so please list these medications: _____

Name(s) of Physician(s): _____
Address: _____ Telephone #: _____

SECTION III

1. Please list all medications you have taken for emotional or psychiatric conditions, beginning with those you are currently taking.

Medication Name	Strength/Dose (mg)	Frequency (i.e. daily, three times/day)	Date Started	Date Discontinued	Reason for Discontinuation

2. Has anyone in your family had a history of or received treatment for a mental illness? (Please note what relation, the nature of the problem, and the subsequent treatment. Please also note if any family member has attempted or committed suicide):

Family Member	Describe problem(s)	Treatment for this problem

3. Have you ever been hospitalized for mental/emotional problems and/or chemical dependency? **Y/N**
   a. If YES, how many times? _____

Describe Problem(s) and Symptoms	Hospital	Date	Treatment(s) (i.e. medication, shock therapy)

SECTION IV

1. Have you ever or do you currently have an eating disorder? **Y / N**
   a. If yes, how did your eating disorder begin? _____
   _____
2. What is the history of your eating disorder up until now? _____
   _____
3. Do you currently restrict your food intake? **Y / N**
4. Have you ever had an episode of binge eating? **Y / N**
5. Do you currently binge eat? **Y / N**
6. During the last three months, how often have you typically had an eating binge? _____
7. At the worst of times, what was the average number of binges per week? _____
   a. When was this? _____
8. Have you ever vomited after eating? **Y / N**
   a. If yes, at what age did you begin to vomit after eating? _____
9. During the last three months, how often have you typically induced vomiting? _____
10. At the worst of times, what was the average number of vomiting episodes per week? _____
    a. When was this? _____
11. Do you or have you ever used laxatives, diet pills, and/or diuretics? **Y / N**
    a. In what quantity and how frequently? _____
    b. When was this? _____
12. Do you or have you ever over-exercised? **Y/N**
    a. If yes, how often and for how long? _____
    b. When was this? _____

SECTION V

ACADEMIC HISTORY

1. Were you ever diagnosed with a learning disability? **Y / N**
   a. If yes, when and what type? _____
2. Did you have special accommodations in school or on standardized testing (e.g. extra time)? **Y / N**
3. Were you ever diagnosed with ADHD? **Y / N**
4. Were you in special education classes/resource room? **Y / N**
5. What was the highest grade completed? _____
6. Did you skip any grades in school? **Y / N**
7. Did you ever repeat any grades in school? **Y / N**

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OCCUPATIONAL HISTORY

1. What is your current occupation? _____
2. When was your most recent job? _____
3. What and when was your longest period of continuous employment? _____

MEDICAL HISTORY

1. Do you have a history of head trauma? **Y / N**
2. Have you ever lost consciousness? **Y / N**
   a. If yes, what was the duration of loss of consciousness? _____

Please read the following statements carefully. Circle how frequently each statement best applies to you.

1. I have trouble listening and paying attention.	Never	Once a Week or Less	Twice a Week	Almost Daily
2. I am not good at focusing on the task I am supposed to be doing.	Never	Once a Week or Less	Twice a Week	Almost Daily
3. I have difficulty paying attention because my mind often drifts and I miss out on important information.	Never	Once a Week or Less	Twice a Week	Almost Daily
4. I am easily distracted from tasks by background noises or activities.	Never	Once a Week or Less	Twice a Week	Almost Daily
5. I have difficulty starting and completing tasks.	Never	Once a Week or Less	Twice a Week	Almost Daily
6. I have trouble working on more than one task at a time.	Never	Once a Week or Less	Twice a Week	Almost Daily
7. I have difficulty being organized.	Never	Once a Week or Less	Twice a Week	Almost Daily
8. I have difficulty thinking through possible solutions to problems.	Never	Once a Week or Less	Twice a Week	Almost Daily
9. I have trouble remembering information like names, directions, and/or dates.	Never	Once a Week or Less	Twice a Week	Almost Daily
10. I intend to do things but often forget (e.g. forget to return phone calls, get things from a store, and keep appointments).	Never	Once a Week or Less	Twice a Week	Almost Daily
11. I am very forgetful about what has been said, done, or read in the last 24 hours.	Never	Once a Week or Less	Twice a Week	Almost Daily
12. I have difficulty remembering where I placed objects of importance, i.e. keys, bills.	Never	Once a Week or Less	Twice a Week	Almost Daily

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SECTION VI

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you think you might have felt. Please answer honestly.

	In the course of the last week....	Not at all	A little	Rather	Much	Very strong
1	It was hard for me to concentrate	0	1	2	3	4
2	I felt helpless	0	1	2	3	4
3	I was absent-minded and unable to remember what I was doing	0	1	2	3	4
4	I felt disgust	0	1	2	3	4
5	I thought of hurting myself	0	1	2	3	4
6	I didn't trust other people	0	1	2	3	4
7	I didn't believe in my right to live	0	1	2	3	4
8	I was lonely	0	1	2	3	4
9	I experienced stressful inner tension	0	1	2	3	4
10	I had images that I was very much afraid of	0	1	2	3	4
11	I hated myself	0	1	2	3	4
12	I wanted to punish myself	0	1	2	3	4
13	I suffered from shame	0	1	2	3	4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15	I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16	Criticism had a devastating effect on me	0	1	2	3	4
17	I felt vulnerable	0	1	2	3	4
18	The idea of death had a certain fascination for me	0	1	2	3	4
19	Everything seemed senseless to me	0	1	2	3	4
20	I was afraid of losing control	0	1	2	3	4
21	I felt disgusted by myself	0	1	2	3	4
22	I felt as if I was far away from myself	0	1	2	3	4
23	I felt worthless	0	1	2	3	4

Now we would like to know in addition the quality of your overall personal state in the course of the last week. 0% means very bad, 100% means excellent. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Very Bad ←----------									----------→ Excellent	

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	During the last month...	Not at all	Once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, head banging etc.	0	1	2	3	4
2	I told other people that I was going to kill myself	0	1	2	3	4
3	I tried to commit suicide	0	1	2	3	4
4	I had episodes of binge eating	0	1	2	3	4
5	I induced vomiting	0	1	2	3	4
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	0	1	2	3	4
7	I got drunk	0	1	2	3	4
8	I took drugs	0	1	2	3	4
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose.	0	1	2	3	4
10	I had outbreaks of uncontrolled anger or physically attacked others	0	1	2	3	4
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	0	1	2	3	4

SECTION VII

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel like I am being punished.

7. Self Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over everything little thing.
3 I feel like crying, but I can't.

11. Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early, can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat more than usual.
2a My appetite is much less than usual.
2b My appetite is much more than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness of Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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SECTION VIII

Please circle the name of any substance from the list below that you used in the last 3 months. In the case of medications, only circle it if you have taken a substance other than prescribed:

Caffeine	Tobacco
Marijuana/Hashish	Cocaine/Crack
Tranquilizers (i.e. Xanax, Valium)	Barbiturates
Inhalants (i.e. poppers, whit its, nitrous oxide)	Methamphetamines (Crystal Meth, amphetamines)
Hallucinogens (i.e. ecstasy, PCP, LSD, angel dust)	Opiates (i.e. Oxycontin, heroin, methadone, morphine)

If you circled any of the above, please indicate how much and how often you have used each substance in the last 3 months:

Caffeine: _____
Tobacco: _____
Tranquilizers: _____
Marijuana/Hashish: _____
Barbiturates: _____
Cocaine/crack: _____
Hallucinogens: _____
Opiates: _____
Methamphetamines: _____
Inhalants: _____

1. Have you ever been treated for alcohol or drug abuse? **Y / N**
   a. When and Where? _____
2. Explain the feeling you get from drinking and or using drugs: _____
3. Describe your behavior when you use: _____
4. Do you intermix drugs and alcohol? **Y / N**
5. What situations make you want to use? _____
6. When was your last drink? _____
7. When did you last use drugs and which drug was it? _____
8. How many times have you tried to stop using drugs or alcohol? _____
9. What was the longest time you were able to stop? _____
10. Explain what you would like to do about your use of drugs or alcohol, if anything: _____

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SECTION IX

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol over the last year. Your answers will remain confidential so please be honest. When you respond to the following questions please answer according to standard drinks. Please choose only one response for each question.

A standard drink is: 12 ounces of beer or 5 ounces of wine or 1.5 ounces of 86 proof liquor

AUD1. How often do you have a drink containing alcohol?

0 Never
1 Monthly or less
2 2 to 4 times per month
3 2 to 3 times per week
4 4 or more times per week
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 1 or 2
2 3 or 4
3 5 or 6
4 7 to 9
5 10 or more
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD3. How often do you have six or more drinks on one occasion?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD4. How often during the last year have you found that you were not able to stop drinking once you had started?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD5. How often during the last year have you failed to do what was normally expected of you because of drinking?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD7. How often during the last year have you had a feeling of remorse or guilt after drinking?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

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AUD8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0 Never
1 Less than monthly
2 Monthly
3 Weekly
4 Daily or almost daily
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD9. Have you or has someone else been injured because of your drinking?

0 No
1 Yes, but not in the last year
2 Yes, in the last year
7 Don't Know
8 Refuse to Answer
9 Not Applicable

AUD10. Has a relative or friend, or a doctor or health worker been concerned about your drinking or suggested you cut down?

0 No
1 Yes, but not in the last year
2 Yes, in the last year
7 Don't Know
8 Refuse to Answer
9 Not Applicable

Signature of patient

Signature of staff member

Date

Date

When you have completed the forms please return them to the front desk. Thank you.

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Columbia Midtown Psychiatry
51 West 51st Street, Suite 340
New York, NY 10019
(212) 326-8441

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

For Patients under age 18, please complete the following:

Parent/Guardian Name #1: _____

Parent/Guardian Name #2: _____

I authorize the releases of my protected health information to and from the following doctors/entities (please include Name, address, and phone number of all parties):

1. Columbia Doctors Psychiatry, 51 West 51st Street, Suite 340, New York, NY 10019. 212-326-8441

2. _____

3. _____

4. _____

The purpose for this request to release medical information is:

☐ Medical Care / Treatment ☐ Other (specify)_____

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 HIPAA release of medical information for will be requested.
- A copy of this signed form will be provided to me.
- 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.

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Please enroll me in the myColumbiaDoctors patient portal.

Complete and return this form to our staff before you leave today.

Patient Name: _____

Date of Birth: _____

Patient E-mail: _____
(for patients 12 or older)

Complete for minor proxy accounts
(patients age 11 or younger):

Parent/Guardian Name: _____

Phone: _____ E-mail: _____

Relationship to Patient: _____

Home Address: _____
Street Address

_____
City State Zip Code

We will send you an e-mail from noreply@followmyhealth.org; just click the link to register.

Thank you for choosing us!