APPLICATION FOR CARE AT CESTARO CHIROPRACTIC

Today's Date: _____ File #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and ages: _____

Name of Emergency Contact: _____ _____Phone #:_____Relationship: _____

Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Please describe your injury in your own words:_____

_____

_____

Have you suffered with any of this or a similar problem in the past? ☐No ☐ Yes If yes, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

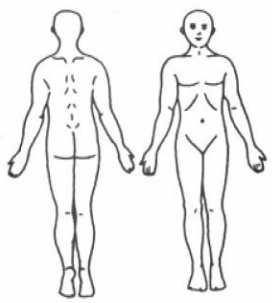
Science tells us your spine should be cared for regularly. How often to you get adjusted by a chiropractor?

☐ Frequently ☐ Only when you hurt ☐ 1x/ month ☐ Never

When was your last complete spinal examination including x-rays? _____ ☐ Never

Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? ☐ No ☐ Yes

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

_____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
DISEASES	→		

Over time spinal misalignments will cause arthritis and degeneration which result in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your neck or back? ☐ Yes ☐ No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in: ☐ Back ☐ Stomach ☐ L Side ☐ R Side

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)
5. **Exercise level:** Never 1 2 3 4 5 6 7 x/wk

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? ☐ Yes ☐ No

I hereby authorize payment to be made directly to Cestaro Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cestaro Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ Today's Date: __/__/__

Continued on next page

Please put a ✔ for any problems that are unresolved or ongoing:

___ Headache	___ Dizziness	___ Prostate Problems	___ Ulcers	
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Neck Disability Index (1000)

This questionnaire has been designed at to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only one box that applies to you. We realize that you may consider that two or more of the statements in any section relate to you, but, please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain. (1001)
- ☐ The pain is mild. (1002)
- ☐ The pain is moderate. (1003)
- ☐ The pain is fairly severe. (1004)
- ☐ The pain is very severe. (1005)
- ☐ The pain is the worst imaginable. (1006)

Section 2: Personal Care

- ☐ I can look after myself normally, without causing extra pain (1007)
- ☐ I can look after myself normally but it causes extra pain (1008)
- ☐ It is painful to look after myself and I am slow and careful (1009)
- ☐ I need help every day in most aspects of self-care (1011)
- ☐ I do not get dressed; I wash with difficulty and stay in bed (1012)

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain (1013)
- ☐ I can lift heavy weights, but it gives me extra pain (1014)
- ☐ Pain prevents me lifting from heavy weights off the floor, but I can manage if they are conveniently placed. Ex- On a table (1015)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned (1016)
- ☐ I can only lift very light weights (1017)
- ☐ I cannot lift or carry anything at all (1018)

Section 4: Reading

- ☐ I can read as much as I want to, with no pain in my neck (1019)
- ☐ I can read as much as I want to, with slight pain in my neck (1020)
- ☐ I can read as much as I want to, with moderate pain in my neck (1021)
- ☐ I can't read as much as I want because of moderate pain in my neck (1022)
- ☐ I can hardly read at all because of moderate pain in my neck (1023)
- ☐ I cannot read at all (1024)

Section 5: Headaches

- ☐ I have no headaches at all (1025)
- ☐ I have slight headaches that come infrequently (1026)
- ☐ I have moderate headaches that come infrequently (1027)
- ☐ I have moderate headaches that come frequently (1028)
- ☐ I have severe headaches that come frequently (1029)
- ☐ I have headaches almost all the time (1030)

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty (1031)
- ☐ I can concentrate fully when I want to with slight difficulty (1032)
- ☐ I have a fair degree of difficulty in concentrating when I want to (1033)
- ☐ I have a lot of difficulty in concentrating when I want to (1034)
- ☐ I have a great deal of difficulty in concentrating when I want to (1035)
- ☐ I cannot concentrate at all (1036)

Section 7: Work

- ☐ I can do as much work as I want to (1037)
- ☐ I can only do my usual work, but no more than that (1038)
- ☐ I can do most of my usual work, but no more than that (1039)
- ☐ I cannot do my usual work (1040)
- ☐ I can hardly do any work at all (1041)
- ☐ I can't do any work at all (1042)

Section 8: Driving

- ☐ I can drive my car without any neck pain (1043)
- ☐ I can drive my car as long as I want with slight pain in my neck (1044)
- ☐ I can drive my car as long as I want with moderate pain in my neck (1045)
- ☐ I can't drive my car as long as I want because of moderate pain in my neck (1046)
- ☐ I can hardly drive at all because of severe pain in my neck (1047)
- ☐ I can't drive my car at all (1048)

Section 9: Sleeping

- ☐ I have no trouble sleeping (1049)
- ☐ My sleep is slightly disrupted (less than I hour sleeplessness) (1050)
- ☐ My sleep is mildly disrupted (1-2 hours sleeplessness) (1051)
- ☐ My sleep is moderately disrupted (2-3 hours sleeplessness) (1052)
- ☐ My sleep is greatly disrupted (3-5 hours sleeplessness) (1053)
- ☐ My sleep is completely disrupted (5-7 hours sleeplessness) (1054)

Section 10: Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all (1055)
- ☐ I am able to engage in all my recreation activities with some neck pain (1056)
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck (1057)
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck (1058)
- ☐ I can hardly do any recreation activities because of pain in my neck (1059)
- ☐ I can't do any recreation activities at all (1060)

Oswestry Disability Questionnaire (0900)

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but, please just check the one statement which most clearly describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain. (0901)
- ☐ The pain is mild. (0902)
- ☐ The pain is moderate. (0903)
- ☐ The pain is fairly severe. (0904)
- ☐ The pain is very severe.(0905)
- ☐ The pain is the worst imaginable. (0906)

Section 2: Personal Care

- ☐ I can look after myself normally without causing extra pain (0907)
- ☐ I can look after myself normally but it causes extra pain (0908)
- ☐ It is painful to look after myself and I am slow and careful (0909)
- ☐ I need some help but can manage most of my personal care (0910)
- ☐ I need help every day in most aspects of self-care (0911)
- ☐ I do not get dressed, wash with difficulty and stay in bed (0912)

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain (0913)
- ☐ I can lift heavy weights but it gives me extra pain (0914)
- ☐ Pain prevents me lifting from heavy weights but I can manage if they are conveniently placed. Ex- On a table (0915)
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned (0916)
- ☐ I can only lift very light weights (0917)
- ☐ I cannot lift or carry anything (0918)

Section 4: Walking

- ☐ Pain does not prevent me from walking any distance (0919)
- ☐ Pain prevents me from walking more than 1 mile (0920)
- ☐ Pain prevents me from walking more than ½ mile (0921)
- ☐ Pain prevents me from walking more than ¼ mile (0922)
- ☐ I can only walk using a stick or crutches (0923)
- ☐ I am in bed/chair most of the time (0924)

Section 5: Sitting

- ☐ I can sit in a chair for as long as I like (0925)
- ☐ I can only sit in my favorite chair as long as I like (0926)
- ☐ Pain prevents me from sitting more than one hour (0927)
- ☐ Pain prevents me from sitting more than 30 minutes (0928)
- ☐ Pain prevents me from sitting more than 10 minutes (0929)
- ☐ Pain prevents me from sitting at all (0930)

Section 6: Standing

- ☐ I can stand as long as I want without extra pain (0931)
- ☐ I can stand as long as I want but it gives me extra pain (0932)
- ☐ Pain prevents me from standing for more than 1 hour (0933)
- ☐ Pain prevents me from me standing for more than 30 minutes (0934)
- ☐ Pain prevents me from standing for more than 10 minutes (0935)
- ☐ Pain prevents me from standing at all (0936)

Section 7: Sleeping

- ☐ My sleep is never disrupted by pain (0937)
- ☐ My sleep is occasionally disrupted by pain (0938)
- ☐ Because of pain I have less than 6 hours sleep (0939)
- ☐ Because of pain I have less than 4 hours sleep (0940)
- ☐ Because of pain I have less than 2 hours sleep (0941)
- ☐ Pain prevents me from sleeping at all (0942)

Section 8: Social Life

- ☐ My social life is normal and causes no extra pain (0943)
- ☐ My social life is normal but causes some extra pain (0944)
- ☐ My social life is normal but is very painful (0945)
- ☐ My social life is severely restricted by pain (0946)
- ☐ My social life is nearly absent because of pain (0947)
- ☐ Pain prevents any social life at all (0948)

Section 9: Changing Degree of Pain

- ☐ My pain is rapidly getting better (0949)
- ☐ My pain fluctuates, but overall is definitely getting better (0950)
- ☐ My pain seems to be getting better, but improvement is slow at the present time (0951)
- ☐ My pain is neither getting better nor worse (0952)
- ☐ My pain is gradually worsening (0953)

Section 10: Traveling

- ☐ I can travel anywhere without pain (0954)
- ☐ I can travel anywhere but it gives me extra pain (0955)
- ☐ Pain is bad but I manage journeys over two hours (0956)
- ☐ Pain restricts me to journeys of less than on hour (0957)
- ☐ Pain restricts me to short necessary journeys under 30 minutes (0958)
- ☐ Pain prevents me from traveling except to receive treatment (0959)

Cestaro Chiropractic
5620 Business Avenue, Suite 7
Cicero, New York 13039
T: (315) 458-0840
F: (315) 458-0777

Financial Policy

Thank you for choosing Cestaro Chiropractic as part of your healthcare team. We look forward to serving the needs of you and your family. We are committed to providing you with quality and affordable health care. We believe in informing our patients, from the beginning, about their financial responsibilities for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- **Insurance & Private Pay Patients:** We participate with several insurance plans, (Excellus Blue Cross/Blue Shield, AETNA, EBS-RMSCO, POMCO, and Medicare). If you are not insured by a plan we do business with, then you are considered a private pay patient and payment in full is expected at each visit. Private pay patients will be provided a receipt that they may use to submit themselves. If you are insured by a plan we do business with, but have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. When we receive verification from your carrier, we will credit your account for any overpayment that has been made. Knowing your insurance benefits is your responsibility. If referral is required, it is your responsibility to make sure that it is in place prior to visiting our office. Please contact your insurance company with any questions you may have regarding your coverage.
- **Co-payments and deductibles:** All co-payments must be paid at the time of service. This agreement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you have a deductible that has not been met when we submit a claim, then you will be responsible for the balance of that claim.
- **Non-covered services/medical necessity:** If an insurance carrier denies a claim due to "medical necessity", you are responsible for payment of that claim. We feel that every treatment we deliver is medically necessary and we realize we have no control over what any insurance carrier defines as medically necessary.
- **Proof of Insurance:** All patients must complete our Patient Information Form before seeing the doctor. We must obtain a copy of your valid insurance card/certificate to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims Submission:** We will submit claims only for insurance plans which we are participating providers with. We will assist you in any way we reasonably can to help get your claims paid. This office does not submit claims for any secondary insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.
- **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
- **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with the doctor. Please be aware that if a balance remains unpaid, we will refer your account to collections. Any accounts that are referred to collections will also be charged a 30% surcharge.

Our practice is committed to providing exceptional chiropractic care to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are here to help!

I have read and understand the Financial Policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

CESTARO CHIROPRACTIC

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, minor fractures, and possible stroke, which occur at a rate of one instance per one million to one per two million, have been associated with chiropractic adjustments. Cauda Equina Syndrome is a serious condition that occurs with compression on the spinal nerve root. If you experience signs or symptoms like the following: saddle paresthesia, inability to feel a bowel movement, or loss of control in bladder, please contact 911 or emergency room immediately.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cestaro Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Cestaro Chiropractic PC
5620 Business Avenue
Cicero, NY 13039
PH: 315-458-0840

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Cestaro Chiropractic PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

CESTARO CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Cestaro at Cestaro Chiropractic at (315)458-0840 If she/he is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: **_____-retaining *page 1 of 2***

CESTARO CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Cestaro Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#

Patient's Signature	Date

Witness	Date

NOTICE OF PATIENT 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 read it carefully.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of this facility, New York Chiropractic College and those of all of the clinics.

All entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or facility operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. for each category of uses or disclosures, we will explain what we man and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical Information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical student or other facility personnel who are involved in taking care of you at the facility. 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.

We may also disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at the facility so your health plan will pay us or reimburse you for the treatment.

For Health Care Operations. We may use and disclose medical information about you for facility operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

To Your Family and Friends. We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or payment for your health care. Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses and disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend alternative treatments, therapies, health care providers or care settings that may be of interest to you.

Health Care Providers and Services. We may use and disclose medical information to tell you about facility-affiliated health care providers and health care services that we provide that may be of interest to you.

Fundraising Activities. We may use medical information about you to contact you in an effort to raise money for the facility and its operations. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the facility. If you do not want the facility to contact you for fundraising efforts, you must notify the Privacy Officer in writing.

Facility Directory. We may include certain limited information about you in the facility directory while you are a patient at the facility. This information may include your name, location in the facility, your general condition and your religious affiliation.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one treatment to those who received another for the same condition.

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

To Avert A Serious Threat to Health or Safety. We may use and disclose medical information about you 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, would only be to someone able to help prevent the threat.

Clinic Quality Assurance Operations – In order to gain an overall view of various elements of this office's operations, individual medical information may be collected, compiled and disseminated. For example, this office may utilize your medical information in order to evaluate the performance of our personnel in providing care to you.

SPECIAL SITUATIONS:

Organ and Tissue Donation. If you are an organ donor, we may release medical 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 medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children; elders and dependant adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;

to notify a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition; and

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when equipped or authorized by law.

Health Oversight Activities. We may disclose medical 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 medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- 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 at the facility; or
- 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.

Disaster Relief. We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but may not include some mental health information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person who conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility.

To request an amendment, your request must be in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement you believe is incomplete or incorrect. If you indicated in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the items or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than for our own uses for treatment, payment and health care operations, as those functions are described above. To request this list or accounting of disclosures, you must submit in writing to the Privacy Officer. You must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

You should indicate in what form you want the list (on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge for costs involved and notify you of the cost so you may choose to withdraw or modify your request prior to costs being incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the on the medical information we disclose about you to someone who is involved in your care or payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to the Privacy officer. In your request, you must tell us:(1) what information you want to limit;(2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

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 at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you for the reasons. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Paper Copy of This Notice. You Have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

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 medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. To file a complaint, contact:

NYCC's Privacy Officer:
Robert Ruddy, D.C.
2360 State Route 89
Seneca Falls, NY 13148
Phone 315-568-3166
Fax 315-568-3700
E-Mail bruddy@nycc.edu

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permissions to use or disclose medical information about you by signing an authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

THIS NOTICE IS IN EFFECT AS OF
04 /14 /2003
Revised 03/14/2006