Chart #_____ Name: _____
DOB: ____/____/_____

Accident / Injury Report

Please fill in all information and PRINT CLEARLY

Name _____ Preferred/Nickname _____ Sex: ☐ M ☐ F
Address _____ City _____ State _____ Zip _____
Home phone _____ Cell phone _____ E-mail _____
Social Security # _____ - _____ - _____ Birthdate _____ / _____ / _____ Age _____
Employer _____ Occupation _____ Employer Phone _____
Employer Address _____ City _____ State _____ Zip _____
Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced.
Spouse's Name _____ Phone # (s) _____
Emergency Contact: Name _____ Relationship _____ Phone_____

How Were You Referred to Our Office?

☐ Referral (who?) _____ ☐ Newspaper/Ad ☐ Insurance Directory
☐ Spinal Screening (where?) _____ ☐ Telemarketing Call ☐ Yellow Pages
☐ Saw Sign (knew location) ☐ Internet ☐ Other _____
☐ Current Patient/Previous Patient

General Health History

Please list any drugs or medications you are taking: _____

Please list any vitamins/herbs/homeopathics you are taking: _____

Have you had any surgeries? Please list:_____

What other health problems do you have? _____

Are you pregnant? ☐Yes ☐No If yes, what month/weeks? _____

Do you smoke? ☐Yes ☐No How much? _____ Do you drink alcohol? ☐Yes ☐No How much?_____

Do you use illicit drugs? ☐Yes ☐No How much?_____ Do you know what an Advanced Directive is? ☐Yes ☐No

Have you been diagnosed with cancer? ☐Yes ☐No Year:_____ Type:_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Chart #_____ Name: _____
DOB: ____/____/_____

Insurance Information

Your Auto Insurance Co. _____ Policy # _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Address for mailing claims:_____ Claim # of accident:_____

Who was responsible for the accident? ➔ Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

Attorney

Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

Date and Time of Accident / Injury

Date _____/_____/_____Time _____:_____ am/pm Accident occurred in the state of: _____

Description of Accident / Injury

What type of vehicle where you in? (Car, Van, Station Wagon, Pickup, Bus, or Other) _____
What was the size of this vehicle? (Compact, Mid-Sized, Full-Sized, or Other) _____
Where were you sitting in the car? (Driver, Front Passenger, Right or Left Rear Passenger, or Middle Rear Passenger)

Was the vehicle you were in:

- ☐ **Stopped** for a traffic light, intersection, stop sign, traffic, pedestrian, a turn, parking, or other? (circle)
- ☐ **Slowing down** for a traffic light, intersection, stop sign, traffic, pedestrian, a turn, parking, or other?
- ☐ **Moving** slowly, moderately, fast, accelerating, _____ m.p.h.
- ☐ **Other** (explain) _____

How much damage did the vehicle that you were in sustain? (Minimal, Moderate, Extensive, Totaled, Don't Know)
What was the type of 1st vehicle that struck you? (Car, Van, Station Wagon, Pickup, Bus, or Other) _____

How did this vehicle strike the vehicle that you were in? (Head-on, Front Right, Front Left, Right, Left, Rear-ended, Sideswiped on Right, Sideswiped on Left, Other) _____
How much damage did this vehicle sustain? (Minimal, Moderate, Extensive, Totaled, Don't Know)

Was there a 2nd vehicle that struck you? ☐Yes ☐No
How did this vehicle strike the vehicle that you were in? (Head-on, Front Right, Front Left, Right, Left, Rear-ended, Sideswiped on Right, Sideswiped on Left, Other) _____
How much damage did this vehicle sustain? (Minimal, Moderate, Extensive, Totaled, Don't Know)

In your own words, please describe what happened:

_____
_____
_____
_____
_____
_____

Chart #_____ Name: _____
DOB: ____/____/_____

Conditions at Time of Accident

What time of day did the accident occur? (Daylight, Dawn, Dusk, or Night)
What was the condition of the road? (Dry, Damp, Wet, Snow Covered, Icy, or Other) _____
What was the visibility at impact? (Good, Fair, or Poor)
If visibility was poor, why? (Sun Light, Darkness, Rain, Snow, Fog, Traffic, Other) _____
_____

At Moment of Impact

Were you aware of a pending collision? ☐Yes ☐No
Was the accident a complete surprise? ☐Yes ☐No
Were you wearing a seatbelt? ☐Yes ☐No
Were you braced for the impact? ☐Yes ☐No
Was your foot on the brake pedal at impact? ☐Yes ☐No
Was it knocked off the pedal? ☐Yes ☐No
What position was the headrest in? (Low, Middle, High, Don't Know)
Did the airbags deploy? ☐Yes ☐No
What position was your body in at time of impact? (Straight, Slouched Forward, Rotated to Right or Left, or Don't Remember)
What direction was your body thrown? (Forward/backward, Backward/forward, Sideways, Across Vehicle, Outside Vehicle, Under Vehicle, Don't Recall, or Other) _____
What position was your head and neck in at time of impact? (Straight, Tilted Forward, Rotated Right, Rotated Left, Don't Recall, or Other) _____
What direction was your head and neck thrown? (Forward/backward, Backward/forward, Sideways, Don't Recall, or Other)
_____

Was a Police Report Filed? ☐Yes ☐No

Result of Impact

Which object/s in the vehicle did the force of the collision cause your BODY to strike?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Right Arm?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Left Arm?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Torso?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Chart #_____ Name: _____
DOB: ____/____/_____

Right Leg?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Left Leg?

☐ Steering Wheel	☐ Dash Board	☐ Windshield
☐ Right Side Door	☐ Left Side Door	☐ Armrest
☐ Right Window	☐ Left Window	☐ Headrest
☐ Ceiling	☐ Console	☐ Shift Lever
☐ Front Seat	☐ Rear View Mirror	☐ Other _____

Immediately after the Accident /Injury

Did you lose consciousness? ☐Yes ☐No

How did you feel? (Confused, Dazed, Dizzy, Nervous, Weak, or Other) _____

Where did you ***immediately*** develop pain?

☐ Head	☐☐ L/R Shoulder	☐☐ L/R Buttocks
☐ Neck	☐☐ L/R Arms	☐☐ L/R Hips
☐ Upper/Mid Back	☐☐ L/R Elbows	☐☐ L/R Thighs
☐ Lower Back	☐☐ L/R Forearms	☐☐ L/R Knees
☐ Pelvis	☐☐ L/R Wrists	☐☐ L/R Legs
☐ Chest/Rib Cage	☐☐ L/R Hands	☐☐ L/R Ankles
☐ Abdomen	☐☐ L/R Feet	
☐ Other _____		

If there were lacerations (cuts), where were they?

☐ Head	☐☐ L/R Shoulder	☐☐ L/R Buttocks
☐ Neck	☐☐ L/R Arms	☐☐ L/R Hips
☐ Upper/Mid Back	☐☐ L/R Elbows	☐☐ L/R Thighs
☐ Lower Back	☐☐ L/R Forearms	☐☐ L/R Knees
☐ Pelvis	☐☐ L/R Wrists	☐☐ L/R Legs
☐ Chest/Rib Cage	☐☐ L/R Hands	☐☐ L/R Ankles
☐ Abdomen	☐☐ L/R Feet	
☐ Other _____		

Describe any other significant injuries:

_____

_____

Did you receive emergency care at the site of the accident? ☐Yes ☐No
If so, what type of emergency care did you receive? (Bandages, Splints, Brace, Neck collar, Other) _____
Where did you go after the accident?_____
How did you get there? _____

Hospital Visit After the Accident / Injury

When did you go to the hospital? (Immediately, Later that day, The next day, Days later, Didn't go) Date: ____/_____/_____
Hospital name: _____ Doctor's name who examined you: _____
Were you admitted? ☐Yes ☐No Date discharged: ___/___/___
Were x-rays taken? ☐Yes ☐No Of what body part/s? _____
Was a CT Scan performed? ☐Yes ☐No Of what body part/s? _____
Was an MRI performed? ☐Yes ☐No Of what body part/s? _____
What was the diagnosis given at the hospital?

_____

_____

Chart #_____ Name: _____
DOB: ____/____/_____

What treatment was administered at the hospital?
☐ Oral Medication ☐ Sutures ☐ Splint ☐ Collar ☐ Injection ☐ Ice Packs
☐ Topical Antiseptics ☐ Hot Packs ☐ Brace ☐ Surgery ☐ Cast ☐ Support
☐ Bandages ☐ Other _____

When you were discharged from the hospital, were you told to see a:
☐ General Practitioner ☐ Chiropractor ☐ Neurologist ☐ Internist
☐ Physical Therapist ☐ Orthopedist ☐ General Surgeon ☐ Plastic Surgeon
☐ Other _____

What recommendations were made?
☐ No Further Care ☐ No Follow-up Instructions ☐ Observations ☐ Time off Work ☐ Rest
☐ Ice ☐ Heat ☐ Collar ☐ Support ☐ Other _____

Were medications prescribed? _____
☐ Pain ☐ Anti-inflammatory ☐ Antibiotic ☐ Nervousness ☐ Other _____

Following the Accident / Injury

How much later did additional symptoms develop? (Immediately, Hours, That evening, The next morning, Days later, A week later, A month later, Other) _____

Mark where any additional ***PAIN*** developed.

☐ Head	☐☐ L/R Shoulder	☐☐ L/R Buttocks
☐ Neck	☐☐ L/R Arms	☐☐ L/R Hips
☐ Upper/Mid Back	☐☐ L/R Elbows	☐☐ L/R Thighs
☐ Lower Back	☐☐ L/R Forearms	☐☐ L/R Knees
☐ Pelvis	☐☐ L/R Wrists	☐☐ L/R Legs
☐ Chest/Rib Cage	☐☐ L/R Hands	☐☐ L/R Ankles
☐ Abdomen	☐☐ L/R Feet	
☐ Other _____		

Mark where any additional ***STIFFNESS*** developed.

☐ Head	☐☐ L/R Shoulder	☐☐ L/R Buttocks
☐ Neck	☐☐ L/R Arms	☐☐ L/R Hips
☐ Upper/Mid Back	☐☐ L/R Elbows	☐☐ L/R Thighs
☐ Lower Back	☐☐ L/R Forearms	☐☐ L/R Knees
☐ Pelvis	☐☐ L/R Wrists	☐☐ L/R Legs
☐ Chest/Rib Cage	☐☐ L/R Hands	☐☐ L/R Ankles
☐ Abdomen	☐☐ L/R Feet	
☐ Other _____		

Mark where any additional ***NUMBNESS*** developed.

☐ Head	☐☐ L/R Shoulder	☐☐ L/R Buttocks
☐ Neck	☐☐ L/R Arms	☐☐ L/R Hips
☐ Upper/Mid Back	☐☐ L/R Elbows	☐☐ L/R Thighs
☐ Lower Back	☐☐ L/R Forearms	☐☐ L/R Knees
☐ Pelvis	☐☐ L/R Wrists	☐☐ L/R Legs
☐ Chest/Rib Cage	☐☐ L/R Hands	☐☐ L/R Ankles
☐ Abdomen	☐☐ L/R Feet	
☐ Other _____		

Chart #_____ Name: _____
DOB: ____/____/_____

Mark where any additional ***TINGLING*** developed.

- ☐ Head
- ☐ Neck
- ☐ Upper/Mid Back
- ☐ Lower Back
- ☐ Pelvis
- ☐ Chest/Rib Cage
- ☐ Abdomen
- ☐ Other _____
- ☐☐ L/R Shoulder
- ☐☐ L/R Arms
- ☐☐ L/R Elbows
- ☐☐ L/R Forearms
- ☐☐ L/R Wrists
- ☐☐ L/R Hands
- ☐☐ L/R Feet
- ☐☐ L/R Buttocks
- ☐☐ L/R Hips
- ☐☐ L/R Thighs
- ☐☐ L/R Knees
- ☐☐ L/R Legs
- ☐☐ L/R Ankles

Since your accident / injury, have you suffered from any of the following?

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Reduced Vision
- ☐ Impaired Hearing
- ☐ Ringing in Ears
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Palpitations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent Urination
- ☐ Inability To Hold Urine
- ☐ Painful Urination

Additionally, have you experienced any of the following?

- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Loss of Balance
- ☐ Tension
- ☐ Reduced Appetite
- ☐ Convulsions
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Weakness
- ☐ Fatigue
- ☐ Other _____
- ☐ Restlessness
- ☐ Insomnia
- ☐ Light Sensitivity
- ☐ Poor Memory
- ☐ Weight Loss
- ☐ Weight Gain

Are you restricted in any of the following as a result of this accident / injury?

☐ Daily Living ☐ Work ☐ Recreation

Explain _____

Have you missed work due to this accident / injury? ☐Yes ☐No

If so, please indicate dates: from _____/_____/_____ to _____/_____/_____

Are you being compensated for time lost from work? ☐Yes ☐No If yes, please state type of compensation you are receiving:_____

Did you self treat your symptoms with:

☐ Ice ☐ Heat ☐ Bed rest ☐ Over the counter medication
☐ Other _____

Did you seek medical care anywhere else? ☐Yes ☐No

Doctor's name: _____

Diagnosis: _____

Treatment recommendation: _____

Is there any additional information about your auto accident that you would like us to know?

_____

_____

_____

_____

_____

Chart #_____ Name: _____
DOB: ____/____/_____

***Notice of Privacy Practices*:** Santoro Chiropractic P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request. By way of my signature, I provide Santoro Chiropractic P.C. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (PRINT) _____

Patient Signature _____ Date _____

Parent or Guardian Name (PRINT)_____

Parent or Guardian Signature_____

Any x-rays taken at this office will remain the property of this office. I authorize Santoro Chiropractic P.C. to release information to my insurance company for payment. I authorize release of information to Santoro Chiropractic P.C. from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature _____ Date _____

Parent or Guardian Signature_____

Doctor Signature: _____Date_____

Chart #: _____ Name:_____

DOB: ___/___/_____

Medication/Supplement List

Medication Name	Dosage	Frequency

Vitamin/Supplement Name	**Dosage**	**Frequency**

Patient or Guardian Signature: _____Date: _____

Doctor Signature: _____ Date: _____

Chart #_____ **Name** _____
DOB ____/____/_____

Santoro Chiropractic P.C.
1177 South 6th Street Suite D
Indiana, Pa 15701

Informed Consent for Chiropractic Treatment

To the patient: You have a right to be informed about your condition, the recommended chiropractic treatment and potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I hereby request and consent to the performance of chiropractic adjustments, procedures, therapies and diagnostic x-rays. The treatment may be performed by Dr. Jeannie Santoro or by a doctor of chiropractic at Santoro Chiropractic P.C.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all the risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which she feels as the time is based upon the facts then known, is in my best interest. I have had opportunity to discuss the risk and benefits of alternative treatment, including no treatment at all.
I have been advised that there are also other risks, including but not limited to fractures, disc injuries, strokes, dislocations sprains/ strains, worsening of spinal conditions, increased symptoms, no improvement of symptoms, soreness of muscles, burns, and frostbite therapy in therapy.

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movements) and death. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.

I have read or have had read to me the above consent. I have had an opportunity to ask questions about its contents, and by signing below agree to the chiropractic adjustment procedures and care. I intend this consent form to cover the entire course of treatment.

_____ _____
PRINT Patient Name ***Signed* Patient Name**, non- minor

_____ _____
PRINT Parent/ Guardian Name for minor patient ***Signed* Parent/ Guardian Name** for minor patient

_____
Witness

_____ _____
Doctor Signature Date

Chart #_____ **Name: _____**
DOB: _____

Patient Health Information Policies for
Santoro Chiropractic P.C.

The patient understands and agrees to allow Santoro Chiropractic P.C. to use his/her Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.

The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his/her PHI. The office will not release any of your records without your written permission.

The patient or guardian consents to use patient's name for the purpose of welcomes, Referrals, Testimonials, Kids photo boards, Birthdays, strictly for special acknowledgements.

I have read and received a copy of the Notice of Privacy Practices for Santoro Chiropractic P.C.

I have read and understand how my (or my dependent's) PHI will be used and agree to these policies and procedures.

_____ _____
Patients or Guardian Signature Date

Santoro Chiropractic P.C. Patient Information and Office Policy

Our goals are three fold: relieve your symptoms, achieve correction, and maintain health. We will attempt to achieve this with specific, compassionate care, in the shortest amount of time as possible.

Often the doctor recommends a series of appointments, and we encourage you to schedule multiple appointments in advance. This is best for your schedule as well as ours. If you need to reschedule, please call in advance so not miss an appointment, but make it up at another time. We will do our best to be as close to your appointment time as possible, and we ask you to be considerate of other patents and arrive promptly as well.

Santoro Chiropractic P.C. will do a special "no charge" consultation with anyone interested in Chiropractic care. There is no charge or obligation in connection with this appointment and is designed to determine if Chiropractic care may help your individual health problem. This does not include an exam or x-rays.

Patient payment policies:
We feel that patient's health needs are paramount; therefore, the payment policy is an attempt to allow you, the patient, to receive the care you need and pay your balance in the least amount of difficulty.

We require that you pay for your visit before being seen by the doctor. The doctor will often make a payment plan that works with your schedule of visits. Doing this saves us all time and your money. There will be a $30 fee for any returned checks.

We require 20% of the first visit charges due on the first day of service. The balance of these charges can be made in payments unless we will be billing your insurance company. Properly documented Workers Compensation, and Personal Injury claims are not required to pay at this time if appropriate forms and liens are signed.

Chart #_____ **Name: _____**
DOB: _____

Established patient care services:

Patients with unpaid balances are required to make regular payments. A finance charge of 1% (one percent) per month is charged on all accounts in which no payment has been received for 60 days or more. You will receive a monthly statement with all your charges and payments itemized. Please review this and retain it for your records.

Our policy on health insurance:
Today most insurance policies do cover Chiropractic care. We will be happy to process all insurance paperwork on your behalf.

Authorization to release medical information to individuals/family members:
In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Santoro Chiropractic to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give you authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **do not** authorize Santoro Chiropractic PC to release any or all information concerning my medical care to any individual concerning my medical care to any individual except as set for above.

_____I **do** authorize Santoro Chiropractic PC to verbally release any or all information concerning my medical care to the following individuals:

_____	_____	_____	_____
Name	Relationship to patient	Phone # Home	Cell
_____	_____	_____	_____
Name	Relationship to patient	Phone # Home	Cell

Please let us know if you have any questions, or if we can be of any further assistance at any time!

I have read the above Santoro Chiropractic P.C. Patient Information and fully understand the statements.

_____ _____
Patient or Guardian Signature Date

_____
Print Patient Name

_____ _____
Doctor Signature Date

Chart #_____ **Name_____**
DOB_____

Notice of Privacy Practices for Santoro Chiropractic P.C.

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.

How your Health Information may be used:
To Provide Treatment: We will use your health Information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between this office and that of referring physicians, clinical and pathology laboratories and other health care personnel providing you treatment. It may be necessary to seek consultation regarding your condition from other health care providers associated with our facility. It is our policy to provide a substitute health care provider, authorized by Santoro
Chiropractic P.C to provide assessment and /or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or any other health emergency.

To Obtain Payment: We may include your health information with an invoice used to collect payment for treatment you receive in this office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations: Your health information may be used in training programs for students, interns and associates. Some of our best teaching opportunities use clinical situations experienced by patients receiving care. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing and credentialing activities.

Patient Communications: We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and curative care possible. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, cards, money, etc. During these times, we may send you a letter, postcard, invitation or a phone call to invite you to participate in the charitable activity. We will provide you with the information about the type of activity, the dates of the activity. We will provide you with information about the activity, the dates and times. We will not disclose any personal information about your condition for the purpose of Santoro Chiropractic P.C. sponsoring fund raising events.

Abuse or Neglect: We will notify government authorities if we believe a patient is a victim abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security: We may be required to disclose to Federal Officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to control or prevention of an epidemic or the understanding of a new side effect of a drug treatment or medical device.

Law Enforcement: As permitted or required by state or federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report crime.

Family, Friends or Care Givers: We may share your health information with those you tell us will be helping with your home care, treatment, medications or payment. We will be sure to ask your permission first. In the event of an emergency, where you might be unable to communicate to us your wishes, we will use our very best judgment in sharing your health information only when it will be important to those in providing your care.

Authorization to use or Disclose Health Information: Other than is stated above or where Federal, State or local law requires us, we will not disclose your health information other that with your written authorization. You may revoke that authorization in writing at any time.

Chart #_____ **Name_____**
DOB_____

Patient Rights: This law is careful to describe that you have the following rights related to your health information:

1. **Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.
2. **Confidential Communications:** You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications,
3. **Inspect and Copy Your Health Information:** You have the right to read and review and copy your health information, including our complete chart, x-ray and billing record. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.
4. **Amend Your Health Information:** You have the right to ask us to update and modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with a written request and describe the reason for the change. Your request may be denied if the health information in question was not created by our office, is not part of our record or if the record containing your information are determined to be accurate and complete.
5. **Documentation of health:** You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Our documentation procedures will enable us to provide information from September 4, 2013. Please let us know in writing the time period for which you are interested. Thank you for limiting your request for no more than three years at a time. We may need to charge you a reasonable fee for your request.
6. **Request a Paper Copy of this Notice:** You have the right to obtain a copy of this notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to provide you this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to alter the terms of this notice. If we do, we will be sure all of our patients receive a copy of the revision. You have the right to express complaints to us or to the Secretary of Health and Human Services. If you believe your privacy rights have been compromised. We encourage you to express your concerns regarding your privacy of information. Please let us know your concerns or complaints in writing.

Santoro Chiropractic P.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy in respect to your personal information. If you have questions, please call 412-496-9403 for a personal conference.

Complaints: Complaints about your Privacy rights, acts, or how an employee has handled your health information should be directed to Dr. Santoro at 412-496-9403.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights
200 Independence Avenue S.W. Room 509F
Washington, DC 20201
I have read the Privacy Notice and understand my rights contained in this notice.
By way of my signature, I provide Santoro Chiropractic P.C. with my authorization and
consent to use and disclose my protected health information for the purpose of treatment and diagnosis.

_____ _____
Patient name (print) Patient or Guardian Signature

_____ _____
Doctor Signature Date