

# Dr. Thomas Cristello, Chiropractor PC

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## Chiropractic Case History

Name \_\_\_\_\_ Gender M F Date \_\_\_\_\_  
Address \_\_\_\_\_ Apt. \_\_\_\_ C \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ How were you referred here \_\_\_\_\_  
Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_

Would you like to receive our periodic newsletter? \_\_\_\_ Yes via email, \_\_\_\_ Yes via postal Mail, \_\_\_\_ No.

**Please list any other Health care providers you are seeing for this condition, and indicate if we may discuss your treatment with them.**

Provider's Name	Provider's address and Phone	May we contact them? Y/N
_____	_____	_____
_____	_____	_____

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse/Partner \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when & reason \_\_\_\_\_

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Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

**1. Primary reason for seeking chiropractic care:**

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**2. Complaint Began when and how?**

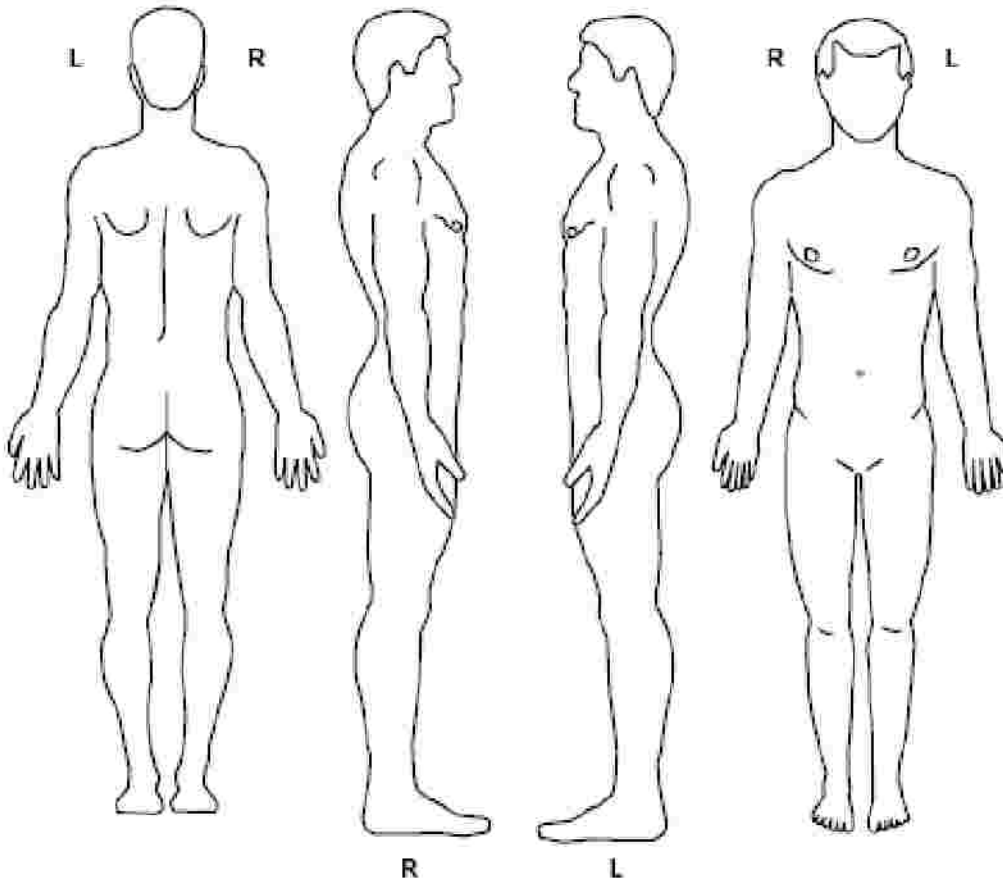
\_\_\_\_\_

Medications? \_\_\_\_\_

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Name \_\_\_\_\_ Date \_\_\_\_\_

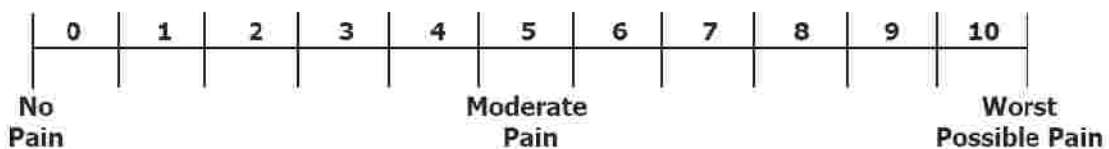


Mark as follows:

A - Ache B - Burning N - Numbness P - Pins & Needles

S - Stabbing O - Other - Describe \_\_\_\_\_

Mark an **X** in the box below the number indicating your level of pain.



928 Broadway, Suite 904 ~ New York, NY 10010 ~ Phone (212) 375-9802 ~ Fax (212) 375-9931 ~

Email: tom@dr cristello.com ~ Web Page: www.dr cristello.com

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## **HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose Personal Health Information for the purpose(s) of Health Insurance.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to \_\_\_\_\_ [identify intended recipients].

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 928 Broadway, Suite 304, New York, NY 10010.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by: Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Assignment and Release of Benefits**

I, the undersigned certify that I (or my dependent) have insurance coverage with:

\_\_\_\_\_, and assign directly to Dr. Cristello, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

Date \_\_\_\_\_

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## Terms of Acceptance

When a patient seeks Chiropractic Health Care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An Adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our Chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a Chiropractic spinal examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral Subluxations. However, we may use other procedures to \_\_\_\_\_ ody hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements. All the questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# *Dr. Thomas Cristello, Chiropractor PC*

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## Abbreviated Notice of Privacy Policy For Dr. Thomas Cristello D.C. Effective April 1, 2003

We collect your personal health information from you through treatment, payment or other means as applicable. Your personal health information is protected by federal law. Generally we do not use or disclose your information without your permission. Once permission has been obtained, we must disclose your personal health information in accordance with the specific terms of permission. The following is an outline of the circumstances under which we are permitted by law to use or disclose your personal health information. You may request a copy of the detailed privacy policy with a written request sent to: Dr. Thomas Cristello D.C., Chiropractor PC, 928 Broadway, Suite 904, New York, NY 10010.

1. Without your consent we may use or disclose your personal health information in order to provide you with services and treatments you may require or request, or to collect payment for services or and to conduct other operations otherwise permitted or required by law. We can also disclose your personal health information within and among our workforce to accomplish the same purposes.
2. As required by law we may use or disclose your personal health information to the extent that such use or disclosure as required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. All other situations, with your specific authorization. Except as otherwise permitted or required, as outlined above, we may not use or disclose your personal health information without your written permission. You may revoke your authorization at any time except in some circumstances.
4. Miscellaneous Activities, NOTICE WE may contact you to provide appointment reminders or information about treatments or other health-related benefits and services that may be of interest to you.

### Your Rights with Respect to your Personal Health Information

1. Right to Request Restrictions on Use or Disclosure
2. Right to Receive Confidential Information
3. Right to Receive Confidential Communications
4. Right to Inspect and Copy Your Personal Health Information
5. Right to Amend Your Personal Health Information
6. Right to Receive and Accounting of Disclosures of Your Personal Health Information
7. Right to file a complaint with us if you believe your privacy rights have been violated. You may submit your complaint in writing by mail to our privacy officer, Thomas Cristello, D.C. within 180 days of when you knew or should have known the act of omission complained of occurred. You will not be retaliated against for filing any complaint.

We reserve the right to amend this privacy policy at any time for which we will provide you with notice within 60 days of the effective date of such revision, amendment or change.