PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date _____/_____/____

Childs Name_____

Date of Birth _____/_____/_____ Age: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____City/State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ Father's Social Security #_____-_____-_____ ☐ Mother's Social Security #_____-_____-_____

☐ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long***

_____

_____

1. **When did the** Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? ___ No ___Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes, describe:

_____

4. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

_____

5. How long ago? _____Days _____Weeks _____Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____

_____

_____

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

☐ Other: _____

I understand that I am directly and fully responsible to Cestaro Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

Consent for Treatment of a Minor

Name of Minor: _____

Date of Birth: _____/_____/_____

I, _____, hereby authorize Dr. Nicole Cestaro and/or whomever she designates as her assistant(s) to administer treatment as deemed necessary to my child, _____.

Parent/Guardian Signature: _____

Witness: _____

Date: _____/_____/_____

Cestaro Chiropractic
5620 Business Avenue, Suite 7
Cicero, New York 13039

Phone: 315-458-0840
Fax: 315-458-0777

www.cestarochiropractic.com

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

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

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
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 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