Patient Quality Of Life Survey Example

TOMASETTI
FAMILY CHIROPRACTIC

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

Patient Quality Of Life Survey Example

TOMASETTI
FAMILY CHIROPRACTIC

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____

TOMASETTI
FAMILY CHIROPRACTIC

PERSONAL HISTORY

Name: _____ Address: _____

City: _____State, Zip code: _____

Home Phone: _____ Social Security #: _____

Cell Phone# and carrier: _____ Work Phone: _____

Email Address (required- used only for private communication) :

_____

Birth Date: _____Age: _____ Gender: ___M ___F

Marital Status (circle): Single Married Separated Divorced Widowed

Employer: _____ Type of Work: _____

Name(s) & age(s)of children: _____

_____

Referred to this office by: _____

Name & Phone number of person responsible for payment: _____

Name & Phone number of emergency contact person: _____

Primary Care Physician: _____ PCP #:_____

CURRENT HEALTH CONCERNS

What do you hope to achieve with your visit here?

_____

What is your primary health concern _____

When was the last time you felt exceptionally well?

_____

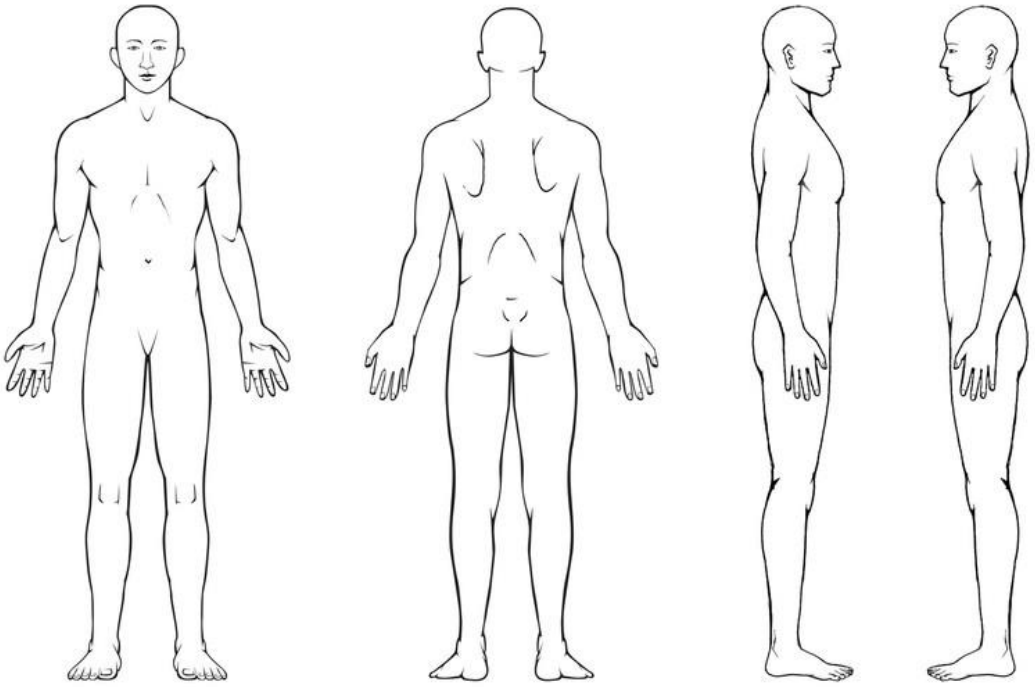
List 3-5 areas of your life this is hindering.
Circle your top 1 or 2 priorities.

1._____
2. _____
3._____
4._____
5._____

List 3-5 ways your life would improve if/ when your health concern improves.
Circle your top 1 or 2 priorities.

1._____
2. _____
3._____
4._____
5._____

Body Diagram:
Please mark **ALL SCARS and injuries / surgeries - regardless of size** and with as much detail as you can. Please write anywhere in the box.



Other comments you think are important?

_____
_____
_____
_____
_____

Review of Systems (√) Yes or No for symptoms in past 6 months, (circle) for symptoms TODAY)

Constitutional/Endocrine
□ Yes □ No Fever
□ Yes □ No Chills
□ Yes □ No Weakness/Fatigue
□ Yes □ No Weight Loss
□ Yes □ No Weight Gain
□ Yes □ No Insomnia
□ Yes □ No Snoring
□ Yes □ No Excessive thirst
□ Yes □ No Excessive urination
□ Yes □ No Cold or Heat intolerance
Other:_____

HEENT
□ Yes □ No Sore Throat
□ Yes □ No Stiff neck
□ Yes □ No Change in your voice
□ Yes □ No Sinus Drainage
□ Yes □ No Sinus Head Ache
□ Yes □ No Nose Bleeds
□ Yes □ No Ear ache/drainage
□ Yes □ No Hearing Loss
□ Yes □ No Ringing in your ears
□ Yes □ No Blurred Vision/Loss
□ Yes □ No Wear glasses or contacts
□ Yes □ No Itchy/watery eyes
□ Yes □ No Dental problems
Other:_____

Gastrointestinal
□ Yes □ No Nausea /Vomiting
□ Yes □ No Difficulty swallowing
□ Yes □ No Hemorrhoids
□ Yes □ No Diarrhea
□ Yes □ No Constipation
□ Yes □ No Bloody or Black Stools
□ Yes □ No Abdominal pain
□ Yes □ No Heart burn/indigestion
□ Yes □ No Frequent use of Laxatives
Other:_____

Urinary
□ Yes □ No Pain or burning with urination
□ Yes □ No Urinary frequency (Night or Day)
□ Yes □ No Blood in urine / Dark urine
□ Yes □ No Incontinence
□ Yes □ No Slow starting or stopping urine
Other:_____

Genital/Sex Organs
□ Yes □ No Penile discharge
□ Yes □ No Testicular lump/pain
□ Yes □ No Breast Pain/discharge/lump
□ Yes □ No Painful intercourse
□ Yes □ No Lack of sexual desire
□ Yes □ No Problems with performance
Other:_____

FEMALE Reproductive
□ Yes □ No Hot Flashes
□ Yes □ No Bleeding after menopause
□ Yes □ No Excessive menstrual bleeding
□ Yes □ No Unusual vaginal discharge
□ Yes □ No Menstrual pain/cramps
□ Yes □ No Spotting between periods
Age at onset of menstruation_____
1st day of last menstruation_____
Last pap smear:_____
Pap Results:_____
Total Pregnancies:_____
Total live births:_____
Total miscarriages:_____
Total abortions:_____
Total C-sections:_____

Cardiac
□ Yes □ No Chest pain
□ Yes □ No Palpitation
□ Yes □ No Irregular heartbeat
□ Yes □ No Exercise intolerance
□ Yes □ No Leg swelling
Other:_____

Respiratory
□ Yes □ No Persistent Cough
□ Yes □ No Coughing up blood
□ Yes □ No Shortness of breath
□ Yes □ No Wheezing
□ Yes □ No Can't breathe laying flat
Other:_____

Skin
□ Yes □ No Rashes/Hives
□ Yes □ No Skin discoloration
□ Yes □ No Lesions/moles/warts
□ Yes □ No Ulcers
□ Yes □ No Itching
□ Yes □ No Nail Problems
□ Yes □ No Unusual Hair loss
□ Yes □ No Easy bruising
Other:_____

Psych
□ Yes □ No Depressed mood
□ Yes □ No Suicidal thoughts/plans
□ Yes □ No Agitation/irritability
□ Yes □ No Insomnia
□ Yes □ No Anxiety
□ Yes □ No Frequent crying spells
Other:_____

Musculoskeletal
□ Yes □ No Joint pains or stiffness
□ Yes □ No Joint swelling
□ Yes □ No Muscle weakness
□ Yes □ No Back pain
□ Yes □ No Muscle spasms/cramps
□ Yes □ No Falling
Other:_____

Neurologic
□ Yes □ No Frequent Headache
□ Yes □ No Seizures
□ Yes □ No Syncope (passing out)
□ Yes □ No Limb weakness
□ Yes □ No Limb numbness
□ Yes □ No Dizziness
□ Yes □ No Swallowing difficulty
□ Yes □ No Balance issues
□ Yes □ No Tremors
□ Yes □ No Rigidity
Other:_____
_____
_____

Current Medications – Prescription and Over-The-Counter

Medication	Dose	Freq.	Start Date	Reason

Previous Medications – last 10 years

_____
_____
_____

Have your medications or supplements caused you unusual side effects or problems? Describe_____	☐ Yes	☐ No
Have you had **prolonged (>3 days) or regular use** of NSAIDs – **Advil, Aleve, Motrin, Aspirin**?	☐ Yes	☐ No
Have you had prolonged or regular use of **Tylenol**? Reason: _____	☐ Yes	☐ No
Do you use NSAIDs now? ☐ _____ times Daily ☐ _____ times Weekly ☐ _____ times Monthly	☐ Yes	☐ No

Have you taken antibiotics more than one time per year?	☐ Yes	☐ No
Have you had long-term use of antibiotics? More than 10 days	☐ Yes	☐ No
Number of lifetime antibiotic treatments? _____		
Have you had prolonged or regular use of acid blocking drugs – Tagamet, Zantac, Prilosec	☐ Yes	☐ No

Have you ever used steroids? ☐ Prednisones ☐ Nasal Allergy Inhalers ☐ Skin/joint creams etc. ☐ Anabolic		☐ No

Patient Birth History: ☐ Term ☐ Premature ☐ Pregnancy Complications _____ ☐ Birth Complications _____ ☐ Breast-fed, How long? _____ ☐ Bottle Fed, How long? _____		
Did you eat candy or sugar more than 3x week as a child?	☐ Yes	☐ No
Age at introduction of • Solid foods _____ • Dairy_____ • Wheat/ Gluten_____		

Dental History

Dental surgery? Wisdom Teeth Extraction?	☐ Yes	☐ No
Do you floss regularly?	☐ Yes	☐ No
Do you brush regularly?	☐ Yes	☐ No
Have you had fluoride treatments?	☐ Yes	☐ No
Do you have the following? ☐ Silver Mercury fillings – how many_____ ☐ Gold fillings ☐ Root canal(s) ☐ Dental Implants ☐ Tooth Pain ☐ Bleeding gums ☐ Gingivitis ☐ Problems Chewing		☐ No
What toothpaste do you use? _____	☐ Yes	☐ No

Environmental History

In your home or work environment are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation (cell, laptop, iPad, Smart Meter) ☐ Mold		☐ No
How often do you use your cell phone? Hours/day_____		
How often do you use your computer? Hours/ day_____ Hours/week _____		
Have you ever turned yellow – jaundiced	☐ Yes	☐ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? If yes, explain_____	☐ Yes	☐ No
Do you dry clean your clothes regularly or frequently	☐ Yes	☐ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure?	☐ Yes	☐ No
Do you have any pets or farm animals?	☐ Yes	☐ No
Do you have a known history of significant exposure to any harmful chemicals such as the following: ☐ Herbicides ☐ Insecticides – frequent visits of exterminator, pesticides ☐ Organic solvents ☐ Heavy/ Toxic metals ☐ Other_____		☐ No
What detergents/soap do you use – brand names?		
What deodorant?		
What beauty products do you use – lotions, hair products, make up, etc. and what brands?		

Readiness Assessment:

Rate on a scale of 5 – very willing- to 1– not willing

In order to improve your health, how willing are you to:

Significantly change your diet	1	2	3	4	5
Take several nutritional supplements each day	1	2	3	4	5
Start preparing your own meals	1	2	3	4	5
Modify your lifestyle	1	2	3	4	5
Practice a relaxation technique	1	2	3	4	5
Engage in regular exercise	1	2	3	4	5
Have periodic lab tests to assess your progress	1	2	3	4	5
Get regular bodywork such as chiropractic or massage	1	2	3	4	5
Setting regular appointments	1	2	3	4	5
Read books or articles to learn about your health and solutions	1	2	3	4	5
Be fully responsible for your own healing	1	2	3	4	5
Make appointments if needed	1	2	3	4	5

Comments: _____
_____
_____
_____
_____

How confident are you of your ability to organize and follow through on the above health related activities? (**Rate on a scale of 5 = very confident to 1 = not confident at all)**

1 2 3 4 5

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the
above activities?

_____
_____
_____
_____

At the present time, how supportive do you think the people in your household will be to you implementing the above changes? Rate on a scale of 5 = extremely supportive to 1 = unsupportive. **(Rate on a scale of 5 = very confident to 1 = not confident at all)**

1 2 3 4 5

How much ongoing support and personal contact – office visits – from the doctor would be helpful to you as you implement your personal health program?

- Daily
- 2-3x per week
- Weekly
- 2-3x per month
- Monthly
- Other_____

Brain Health and Nutrition Assessment Form™ (BHNAF)

Name:_____ **Age:**_____ **Sex:**_____ **Date:**_____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease **Yes or No**
- Family members who have been diagnosed with an autoimmune disease **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests **0 1 2 3**
- Feel overwhelmed with ideas to manage **0 1 2 3**
- Feelings of inner rage or unprovoked anger **0 1 2 3**
- Feelings of paranoia **0 1 2 3**
- Feelings of sadness for no reason **0 1 2 3**
- A loss of enjoyment in life **0 1 2 3**
- A lack of artistic appreciation **Yes or No**
- Feelings of sadness in overcast weather **0 1 2 3**
- A loss of enthusiasm for favorite activities **0 1 2 3**
- A loss of enjoyment in favorite foods **0 1 2 3**
- A loss of enjoyment in friendships and relationships **0 1 2 3**
- Inability to fall into deep, restful sleep **0 1 2 3**
- Feelings of dependency on others **0 1 2 3**
- Feelings of susceptibility to pain **0 1 2 3**

SECTION 11

- Feelings of worthlessness **0 1 2 3**
- Feelings of hopelessness **0 1 2 3**
- Self-destructive thoughts **0 1 2 3**
- Inability to handle stress **0 1 2 3**
- Anger and aggression while under stress **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep **0 1 2 3**
- A desire to isolate yourself from others **0 1 2 3**
- An unexplained lack of concern for family and friends **0 1 2 3**
- An inability to finish tasks **0 1 2 3**
- Feelings of anger for minor reasons **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) **Yes or No**
- A decrease in verbal memory **0 1 2 3**
- Occurrence of memory lapses **0 1 2 3**
- A decrease in creativity **0 1 2 3**
- A decrease in comprehension **0 1 2 3**
- Difficulty calculating numbers **0 1 2 3**
- Difficulty recognizing objects and faces **0 1 2 3**
- A change in opinion about yourself **0 1 2 3**
- Slow mental recall **0 1 2 3**

SECTION 13

- A decrease in mental alertness **0 1 2 3**
- A decrease in mental speed **0 1 2 3**
- A decrease in concentration quality **0 1 2 3**
- Slow cognitive processing **0 1 2 3**
- Impaired mental performance **0 1 2 3**
- An increase in the ability to be distracted **0 1 2 3**
- Need coffee or caffeine sources to improve mental function **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason **0 1 2 3**
- Feelings of dread **0 1 2 3**
- Feelings of a “knot” in your stomach **0 1 2 3**
- Feelings of being overwhelmed for no reason **0 1 2 3**
- Feelings of guilt about everyday decisions **0 1 2 3**
- A restless mind **0 1 2 3**
- An inability to turn off the mind when relaxing **0 1 2 3**
- Disorganized attention **0 1 2 3**
- Worry over things never thought about before **0 1 2 3**
- Feelings of inner tension and inner excitability **0 1 2 3**

SIGNATURE PAGE

Please read the following documents:

- Consent to Chiropractic
- Treatment Notice of Privacy Practices

Sign your agreement on this form which will be a part of your records. You may keep the consent and HIPPA documents for your reference.

Thank you!

CONSENT TO CHIROPRACTIC EXAMINATION / TREATMENT

I hereby authorize Dr. Adam Tomasetti and/or whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:_____ Date:_____

HIPPA – PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Tomasetti Family Chiropractic.

Signature:_____ Date:_____

CONSENT TO TREATMENT OF A MINOR (IF APPLICABLE)

I hereby authorize Tomasetti Family Chiropractic, Dr. Adam Tomasetti and/or whomever is designated as assistants to administer chiropractic examination, treatment as deemed necessary to my child.

Name of Child:_____

Signature of Parent / Guardian:_____ Date:_____

CONSENT TO CHIROPRACTIC TREATMENT

The primary treatment used is the spinal adjustment.
We may use this procedure to treat you.

1. **THE NATURE OF CHIROPRACTIC ADJUSTMENT**

   We will use our hands or a mechanical device on your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sensation of movement.

2. **THE MATERIAL RISK INHERENT IN CHIROPRACTIC ADJUSTMENT**

   As with many health care procedures, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients feel some stiffness and soreness following the first few days of treatment.

3. **PROBABILITY OF THOSE RISKS OCCURING**

   Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and/or x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Please sign the "Signature Page" for our records. You may keep this copy for your records.

I hereby authorize Dr. Adam Tomasetti and/or whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Tomasetti Family Chiropractic – Dr. Adam Tomasetti has adopted the following privacy policies:

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of our office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of the information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information may be used by our staff to notify you of appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information

2. The right to receive confidential communications concerning your medical condition and treatment;
3. The right to inspect and copy your Protected Health Information;
4. The right to amend or submit corrections to your Protected Health Information;
5. the right to receive an accounting of how and to whom your Protected Health Information has been disclosed; and
6. The right to receive a printed copy of this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or your chiropractor.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to your chiropractor outlining your concerns at:

Tomasetti Family Chiropractic
Attn. Dr. Adam Tomasetti
3808 Market Street
Camp Hill, PA 17011

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is Dr. Adam Tomasetti at the address above.

** HIPPA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law, 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information. It impacts all areas of the health care industry.

Please sign the "Signature Page" for our records. You may keep this copy for your records.

HIPPA – PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Tomasetti Family Chiropractic.

_____

Signature

_____

Date