Cappiello Chiropractic
562 Saratoga Rd.
Scotia, NY 12302
Phone 518-399-2252
Fax 518-399-4712

Due to "new" privacy regulations enacted from former President Clinton (1996) that are in effect as of 2003, the Cappiello Chiropractic Office must have permission from their practice members for certain office procedures that take place within the office and through everyday mailings.

I, ____, give the Cappiello Chiropractic office permission to the following office procedures:

_____display name on the Referral Board
_____ send Birthday and Re-call cards
_____ display Kid-Profile on the wall
_____ Testimonial book
_____ Monthly statements
_____ Name in appointment book in view of counter
_____ Sign in sheet
______Christmas cards on display
______patient file on counter/clipboard
______open door adjusting

This office uses and discloses your protected health care information for the following reasons:

***To share with other treating health care providers regarding your health care.**
***To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.**
***To determine patient's benefits in a health care plan.**
***Releasing information required by State or Federal Public Health law.**
***To assist in overcoming a language barrier when caring for a patient.**
***Business associates providing written assurances for your privacy have been attained.**
***Emergency situations.**
***Abuse, neglect or domestic violence.**
***Appointment reminders to household members or answering machines.**
***Sign-in logs may be disclosed to verify office visits.**

Any other uses or disclosures will only be made with your specific written authorization.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking staff.

I acknowledge that I have received and reviewed this notice with full understanding.

____ Date____________
Name of Patient (Print) Signature of Patient/Legal Representative