APPLICATION FOR TREATMENT
CONFIDENTIAL PATIENT INFORMATION

(PRINT ALL INFORMATION LEGIBLY IN BLACK INK ONLY)

PATIENT

Last Name	First Name	MI	Sex M F	DOB	Age	S.S. #

Street Address	City	State	Zip	Home Phone #	Cell Phone #

Employer	Email Address

Employer Street Address	City	State	Zip	Occupation	Employer Phone #

Spouse's Name	Occupation

PRESENT COMPLAINT

Please utilize the space below to describe your problem:

Please list any other doctor's seen for this complaint:

Have you been hospitalized for this condition? ☐ YES ☐ NO How many days?

Have you missed any days from work? ☐ YES ☐ NO How many days?

INSURANCE

Name & address of PRIMARY Insurance Company

Name of Insured	Dependent	Subscriber ID#	Ins. Co. Phone #

Name & address of SECONDARY Insurance Company

Name of Insured	Dependent	Group ID/Policy #	Ins. Co. Phone #

Medicare/Medicaid #

PCP

Primary Physician's Name	Phone #

Physician's Address	Date of Last Visit

POLICY

I have been informed of ISLANDWIDE CHIROPRACTIC, P.C.'s financial policy. I understand that payment for all services rendered remain my responsibility. I will satisfy this obligation in the following manner: ☐ CASH ☐ CHECK

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

AUTHORIZATION

I, the undersigned, have insurance coverage with the above named insurance company (ies) and assign directly to ISLANDWIDE CHIROPRACTIC, P.C. 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 the above insurance company (ies). I hereby authorize ISLANDWIDE CHIROPRACTIC, P.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

ISLANDWIDE CHIROPRACTIC, P.C.

MEDICAL HISTORY

PLEASE CHECK THE BOX OF ANY CONDITION OR SYMPTOM YOU HAVE HAD IN THE PAST OR ARE CURRENTLY EXPERIENCING.

****Don't forget to sign the bottom of this page upon completion!****

General History

- ❑ Trauma/injuries
- ❑ Height change
- ❑ Weight change
- ❑ Fever/Chills
- ❑ Sweats
- ❑ Allergies
- ❑ Anemia
- ❑ Bleeding/bruising
- ❑ Malaise/fatigue
- ❑ Weakness
- ❑ Cancer

Family History

- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Kidney disease
- ❑ High blood pressure
- ❑ Heart disease/stroke
- ❑ Musculoskeletal disease
- ❑ Cancer
- ❑ Arthritic Conditions
- ❑ Other_____

Gastrointestinal System

- ❑ Change in appetite
- ❑ Food Intolerance
- ❑ Nausea/Vomiting
- ❑ Vomiting of blood
- ❑ Pelvic ulcer
- ❑ Indigestion/heartburn
- ❑ Abdominal pain
- ❑ Gas
- ❑ Change in stool/color/etc.
- ❑ Diarrhea
- ❑ Hernia
- ❑ Hemorrhoids
- ❑ Gallbladder disease
- ❑ Pancreatitis
- ❑ Alcohol intake
- ❑ Type _____
- ❑ Amount_____
- ❑ Other_____

Cardiovascular System

- ❑ Shortness of breath
- ❑ Time of day _____
- ❑ How often_____
- ❑ Sudden calf pain/while walking
- ❑ How often_____
- ❑ High blood pressure
- ❑ Past heart disease
- ❑ Rheumatic fever
- ❑ Other _____

Urinary System

- ❑ Frequent urination
- ❑ ____Day/____Night
- ❑ Daily fluid intake_____
- ❑ Pain during urination
- ❑ Change in urine/color/etc.
- ❑ Difficulty starting stream
- ❑ Difficulty holding urine
- ❑ Discharge
- ❑ Flank pain
- ❑ Urinary tract infections
- ❑ Kidney disease
- ❑ Pelvic pain
- ❑ Other_____

Skin/Hair/Nails

- ❑ Change in skin texture
- ❑ Change in skin temperature
- ❑ Skin dryness/ wetness
- ❑ Unusual skin coloration
- ❑ Rashes/itching sores
- ❑ Skin growths
- ❑ Mole changes
- ❑ Skin cancer
- ❑ Skin pain
- ❑ Change in hair texture/condition
- ❑ Change in hair growth/loss
- ❑ Change in shape of finger or toe nail
- ❑ Change in color of nails
- ❑ Other _____

_____

_____

Respiratory System

- ❑ Difficulty in breathing
- ❑ Cough
- ❑ Blood in sputum
- ❑ Wheezing/Asthma
- ❑ Tuberculosis/exposure
- ❑ Pneumonia/Lung infections
- ❑ Cigarette Smoking history: Daily #_____ Years_____
- ❑ Other tobacco use/cigar___pipe___
- ❑ Chewing tobacco___ Amount____Years___
- ❑ Environmental exposure Type____Amount____

Eye/Ear/Nose/Throat

- ❑ Visual problems
- ❑ Eye irritations
- ❑ Pain in the eyes
- ❑ Other eye problems
- ❑ Difficulty hearing/deaf
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Ear growth/discharge
- ❑ Ear pain
- ❑ Nose bleeds
- ❑ Change in ability to smell
- ❑ Sneezing
- ❑ Nose growths/discharge
- ❑ Nose pain
- ❑ Sinusitis

Patient Signature/Date: _____

ISLANDWIDE CHIROPRACTIC, P.C.

MEDICAL HISTORY (CONTINUED)

Musculoskeletal System

- ❑ Joint stiffness, decreased motion
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle cramps
- ❑ Muscle weakness
- ❑ Muscle wasting
- ❑ Neck pain
- ❑ Mid back pain
- ❑ Low back pain
- ❑ Sacroiliac pain
- ❑ Tailbone pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Fractures, dislocations, sprains or strains_____

_____

- ❑ Other injuries_____

_____

_____

- ❑ Other problems_____

_____

_____

Diet-Vitamins

- ❑ Do you eat meals sporadically?
- ❑ Do you have an unusual appetite? ___large___small
- ❑ Do you skip breakfast?
- ❑ Do you eat between meals?
- ❑ Do you eat a late night snack before bed?
- ❑ Do you eat junk food?
- ❑ Are you on a special diet?
- ❑ Are you a vegetarian? How long? _____
- ❑ Are you taking any supplements? (*Please specify*)_____

_____

Implants

- ❑ Breast implants
- ❑ Cardiac pacemaker
- ❑ Penile
- ❑ Other_____

Neurological System

- ❑ Headaches
- ❑ Epileptic seizures
- ❑ Tics/spasms
- ❑ Dizziness/fainting
- ❑ Disturbances of sensation
- ❑ Unusual weakness
- ❑ Head trauma
- ❑ Stroke
- ❑ Other_____

_____

Psychological History

- ❑ Anxiety
- ❑ Depression
- ❑ Hospitalization/ therapy
- ❑ Other_____

_____

Endocrine System

- ❑ Heat/Cold intolerance
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Neck surgery/Irradiation

Other_____

Breasts

- ❑ Bumps/lumps/mass
- ❑ Pain/tenderness
- ❑ Dimples in breast
- ❑ Change in color/size/shape
- ❑ Nipple discharge
- ❑ Other_____

Reproductive System

- ❑ Genital lesions/sores
- ❑ Genital mass/growths/pain
- ❑ Syphilis
- ❑ HIV positive
- ❑ Gonorrhea
- ❑ Change in sex drive
- ❑ Birth control method

Type_____

How long _____

- ❑ Other sexual difficulties_____

_____

_____

Hospitalizations and Medications

- ❑ Other hospitalizations not listed_____

_____

_____

- ❑ Current use of any drugs (prescription and/or recreational)_____

_____

_____

FEMALE PATIENTS ONLY ★ ★

Menstruation/Obstetrics

Menarche (First period)

- Age ____

Menstrual flow

❑ Scant ❑ Light

❑ Moderate ❑ Heavy

Menstrual regularity:

Days in cycle_____ Duration _____days

Menstrual cramping: *Pain level*

0 1 2 3 4 5

First day of last cycle _____/_____/_____

Date of last PAP test _____/_____/_____

Menopause: Onset _____

- ❑ Post menopausal bleeding
- ❑ Abnormal/painful premenstrual fluid retention
- ❑ Other feminine problems
- ❑ PMS (Premenstrual syndrome)
- ❑ Hysterectomy—Date: _____/_____/_____
- ❑ Pregnancies—How many? _____
- ❑ Children—How many? _____
- ❑ Difficult delivery—How many? _____

Patient Signature/Date: _____

ISLANDWIDE CHIROPRACTIC, P.C.

MEDICAL HISTORY (CONTINUED)

DESCRIBE WHEN YOUR PRESENT SYMPTOM(S) STARTED

How did your symptom(s) start?
- ❑ Gradual onset
- ❑ Motor vehicle
- ❑ Work injury
- ❑ Injury other than the other 3
- ❑ Other _____

When did your symptom(s) start? (day - month - year) _____/_____/_____

MEDICATIONS

List **all** medications you are taking	Type	Amount taken per day	Condition taken for

Types of medications (Rx – prescription OTC – over the counter)

- ❑ Anti-depressant – Rx
- ❑ Anti-inflammatory – Rx
- ❑ Muscle relaxant – Rx
- ❑ Narcotic/codeine – Rx
- ❑ Acetaminophen, aspirin, ibuprofen –OTC
- ❑ Other – describe above

SURGERIES

List **all** surgical procedures	Date performed	Condition performed for

TOBACCO AND ALCOHOL USAGE

Cigarette usage:
- ❑ Non-smoker, never smoked
- ❑ Non-smoker, used to smoke
- ❑ Smoke less than ½ pack per day
- ❑ Smoke 1-2 packs per day
- ❑ Smoke more than 2 packs per day

How many years have you/did you smoke? _____

How many **alcoholic** beverages (*i.e.: beer, wine liquor*) do you consume in an average week? _____

Has your use of alcohol or other chemicals increased since your symptom(s) began? ❑ **YES** ❑ **NO**

LEGAL AND INSURANCE INFORMATION

Are you currently, or do you anticipate, being involved in any litigation relating to your symptom(s)?
YES ❑ **NO** ❑

Indicate the type of disability benefits you are receiving, or applying for:

- ❑ Workers compensation
- ❑ Auto insurance
- ❑ Long term disability
- ❑ Social security
- ❑ General assistance
- ❑ None
- ❑ Other _____

Patient Signature/Date: _____

ISLANDWIDE CHIROPRACTIC, P.C.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, or whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name_____ Signature of Patient_____
PLEASE PRINT

Date Signed_____ Doctor's Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name_____ Signature of Patient_____
PLEASE PRINT

Date Signed_____ Signature of Representative_____

Relationship or Authority of Patient's Representative_____

Translated by_____ Date_____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Office ISLANDWIDE CHIROPRACTIC, P.C.

Address 230 Hilton Ave Ste 220 Hempstead NY 11550

Name of Doctor's treating this patient:

1._____ NPI#_____
PLEASE PRINT

2._____NPI#_____

ISLANDWIDE CHIROPRACTIC, P.C.

Islandwide Chiropractic, P.C.
Dr. Stan Velkovich, D.C.
230 Hilton Ave, Suite 220
Hempstead, NY 11550-8116
-Official Team Chiropractor of the USTA

Cancellation Policy/No Show Policy For Doctor Appointments

Cancellation/Missed Appointments/No Shows for Doctor Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work and family. However, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment. Also, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Effective August 1, 2009 there will be a **$50.00 charge for all missed appointments and appointments that are not cancelled 24 hours prior to the visit**. Since Dr. Velkovich sees patients from all over the country we ask that you respect his time and that of other patients.

Missed appointment charges are not billable through your insurance company. Please remember that when you do miss an appointment, your copayment does not apply.

Reminder calls are made the business day before your next appointment. At times, our office may be busy and is unable to confirm your appointment. If you do not receive a reminder call and forget your appointment, you are still liable for the missed appointment charge. Our reminder calls are a **courtesy only**.

Dr. Velkovich respects your time in that he does not overbook. If you follow our new policy and **advise us 24 hours in advance** to reschedule an appointment, there will be no extra charge applied. We are not raising our fees, only requesting that you notify us in advance should you need to reschedule your appointment.

Scheduled Appointments
We understand that delays can happen, however, we must try to keep the other patients and doctors on time.
If a patient is 15 minutes past their scheduled time, we may charge you for a missed appointment.

Account Balances
We will require that patients with account balances, pay their outstanding balances to zero ($0) prior to services rendered. Patients who have questions about their bills, or who would like to discuss a payment plan option may call and ask to speak with Melissa, the Office Manager. Patients with balances over $50 must make payment arrangements prior to future appointments made.

Patient Name (Print)	Patient/Guardian Signature	Date

• Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

• National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

• Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.

• Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

• a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;

• the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

• the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or

(iv) Is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to the Practice's Privacy Officer, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;
(ii) incident to a use or disclosure otherwise permitted or required by applicable law;
(iii) pursuant to a written authorization obtained from you;
(iv) to persons involved in your care or for other notification purposes as provided by law;
(v) for national security or intelligence purposes as provided by law;
(vi) to correctional institutions or law enforcement officials as provided by law;
(vii) as part of a limited data set as provided by law; or
(viii) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to the Practice's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the Practice's Privacy Officer, Stan Vetkovich, [illegible] (516) 248-2870.

This notice is effective as of April 14, 2003.

I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY NOTICE:

_____ _____
Signature *Date*

Refused: _____ _____
Signature *Date*

ISLANDWIDE CHIROPRACTIC, P.C.
230 HILTON AVE SUITE 220
HEMPSTEAD NY 11550

PRIVACY NOTICE

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.

INTRODUCTION

Islandwide Chiropractic, P.C. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. 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. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- *Health care operations* means the support functions of our Practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for treatment or medical care.

- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may disclose to your family or friends or any other individual identified by you protected health information directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick-up medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may contact you as part of our efforts to market our Practice's services as permitted by applicable law.

- Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

- **[We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.]**

- We will use or disclose protected health information about you when required to do so by applicable law.

- **[Note: In accordance with applicable law, we may disclose your protected health information to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.]**

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

- Organ and Tissue Donation. If you are an organ donor, we may release health 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 health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.

- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:

  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government auth[illegible] if we believe that an adult patient has bee[illegible] victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Practice is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.

- Law Enforcement. We may release health 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 under certain limited circumstances;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct on our premises; and
  - In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.