CARUCCI CHIROPRACTIC CENTER, PLLC
3684 Battery Lane
Southport, NC 28461
(860) 214-1087

ALTHORIZATIONS

Carucci Chiropractic Center may need to use your name. address, phone number and your clinical records to contact you with appointment reminders/missed appointments, birthday cards, thank you 'sand newsletters or other health related infonnation that may be of interest to you either directly, through the mail or through the internet. If this contact is made by the phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with regard to the above mentioned communications. In addition, we ask you to sign mat the front desk when you arrive. We occasionally ask our patients to fill out and sign a patient testimonial and we recognize children patients for our bulletin board. By signing this form, you authorize us to allow your name to appear on the sign-in sheet, reception room testimonial book, thank you board, and for your child's picture to appear on the bulletin board.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who bas access to the reminder, birthday card, or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the infonnation that we use to contact you to provide appointment reminders/missed appointments, birthday cards, thank you's, newsletters, or other health related information at any time.

This notice is effective as of_____ _ . This authorization will expire seven years after the date on which you last received services from this office.

I authorize you to use or disclose my health infonnation in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name (printed) Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative (printed) Personal Representative Signature

_____
Description of personal representative's authority to act for this patient

Notice of Privacy Practices for Protected Health Information

Your Right to Complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Vwu le you may make an oral complaint at any time, written comments should be addressed to:

Carucci Chiropractic Center
3684 Battery Lane
Southport, NC 28461

U.S. Department of Health & Human
Services 200 Independence Avenue, S.W.
Washington, D.C. 20201

To Contact Us

If you would like further information about our privacy policies and practices, please contact:

Dr. Gina M. Carucci
3684 Battery Lane
Southport, NC 28461
860-214-1087

This notice is effective as of _____ . This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
Patient Name (printed) Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative (printed) Personal Representative Signature

_____
Description of Personal Representative's authority to act for the patient

Patient Name:	DOB:	File#:	
Cender:	Male	Female	
Race/ Ethnicitv:	African American Asian	American Indian Caucasusian	Hisoanic Native Hawaiian and Other Pacific Islander
Preferred Spoken Language:	Enelish	Other:	
Tobacco Use: Y/ N	Amount oer day:	[oterested in Stoooine use: Y/N	
Illicit Drug Use: Y/N			
Alcohol Use: Y/N	Amount ocr dav:	Week: Month:	
Coffee Use: Y/N	Amount per dav:	Weck: Month:	
Cardiovascular Exercises: Y / 1'	Minutes per day:	Hours oer week:	
Tvoe of Exercises:	Walk (Treadmill/ outside)	Freauencv:	
	Run (Treadmill/ outside)		
	Bike (Stationarv / outdoors)		
	Swim		
	Yoga		
	Aerobics		
	Pilates		
	Tai Chi		
	Martial Arts		
	Other:		
Weight Lifting:	Part of Bodv:	Freauencv:	
	Uooer body		
	Lower body		
	Back and Abdomen		
	All		
	Date/ Results	Date/Results	Date/Results
Mammoeraohv/ Thcrmo11raphy			
BMD			
Colonoscoov			
Eve Exam			
Soiromctry			
EKC			
Stress Test			
Doooler			
Cas Pro			

Doctor Name	Tvoe of Doctor (i.e. Cardiolo!!ist, etc.)	Phone Number		
Pharmacy	Phone Number			
Name ofDrug/Suoolement	Prescribing MD	Dose	Freauencv	Date Started

Patient Name: Patient Date of Birth:

List of Drugs/ Su1rnlements you are Allergic to	Ty e of Reaction

File#: