

**Perestam Chiropractic, P.C.
159B McMaster Street
Owego, NY 13827
607-687-0800
607-687-3942 Fax****Perestamchiro@hotmail.com** **PerestamChiropractic.com**

Dear New Patient,

We are looking forward to seeing you in our office as a new patient. There are a few things we want you to be aware of before you come in for your scheduled appointment.

Perestam Chiropractic P.C. does not accept any insurance. You may be able to send it in to your insurance on your own and they will determine your reimbursement. We are also non-participating provider with Medicare. This means the day of your visit we would expect payment and then we send each visit into Medicare, and Medicare sends a check to you for those visits.

On your first visit to our office, Dr. Alan R. Perestam will spend about an hour with you. The visit will consist of a consultation and an adjustment. A follow-up appointment may be set up on the doctor’s recommendations. The first visit fee will be around $125.00. Any visits after that will be no more than $65.00.

Attached to this letter is a personal information sheet and consent form that should be filled out and brought to your appointment. If you need to cancel your appointment for any reason please contact our office within 24 hours.

Thanks again, and if you have any questions please do not hesitate to call.

Sincerely,

Dr. Alan R. Perestam and Staff

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**Confidential Personal Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_
Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Can we leave a message at the above numbers? \_\_\_\_\_\_ If not, list which ones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_
Sex: M / F Marital Status S M W D Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you had chiropractic care previously? \_\_\_\_\_\_\_\_\_ If yes, with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Height \_\_\_\_ Weight (current) \_\_\_\_\_ One Yr. Ago \_\_\_\_ Adult Max \_\_\_\_ Age \_\_\_\_Adult Min \_\_\_\_ Age\_\_\_\_
Known Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Blood Type \_\_\_\_\_\_\_\_\_\_\_\_Have you ever had a blood or plasma transfusion? Yes / No
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Last Physical Exam \_\_\_\_\_\_\_\_\_\_\_ With Whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Reported Findings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Surgeries, Hospitalizations, Serious Illness (Last Year in Brackets) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Fractures, Dislocations, Major Dental Work (Last Year in Brackets) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Conditions You Have Had
\_\_\_AIDS/HIV \_\_\_Depression \_\_\_High Blood Pressure \_\_\_Prostate Problems \_\_\_\_Alcoholism
\_\_\_Diabetes \_\_\_High Cholesterol \_\_\_Prosthesis \_\_\_Allergies \_\_\_Digestive Disorders
\_\_\_Hypogylcemia \_\_\_Rheumatic Fever \_\_\_Anemia \_\_\_Dizziness \_\_\_Neck Pains \_\_\_Anorexia
\_\_\_Sinus Troubles \_\_\_Epilepsy \_\_\_Nervousness \_\_\_Stroke \_\_\_Arthritis/Joint Pain \_\_\_Fatigue
\_\_\_Neuritis \_\_\_Tuberculosis \_\_\_Asthma \_\_\_Gout \_\_\_Numbness \_\_\_Ulcer \_\_\_Backaches
\_\_\_Headaches \_\_\_Osteoporosis \_\_\_Urinary Trouble \_\_\_Bleeding Disorders \_\_\_Heart Trouble
\_\_\_Pacemaker \_\_\_Venereal Disease \_\_\_Breathing Problems \_\_\_Hepatitis \_\_\_Parasites
\_\_\_Weight Loss \_\_\_Bulimia \_\_\_Hernia \_\_\_Pinched Nerve \_\_\_Yeast/Candida \_\_\_Cancer
\_\_\_Herniated Disc \_\_\_Poor Circulation Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Purpose of Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other Doctors Seen for this Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever been treated for any other condition in the past year? Yes / No (If so describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Habits
Do you smoke? Y / N What? \_\_\_\_\_\_\_\_\_\_\_ How many/Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since When? \_\_\_\_\_\_\_\_\_\_
Other Tobacco Products? Y / N What? \_\_\_\_\_\_\_\_\_\_\_How many/Day\_\_\_\_\_\_\_\_\_\_\_ Since When \_\_\_\_\_\_\_\_
Drink Coffee? Y / N Cups / Day? \_\_\_\_\_\_\_\_\_\_\_\_ Drink Caffeinated Tea ? Y / N Cups/Day? \_\_\_\_\_\_\_
Colas/Soft Drinks? Y / N /number a day? \_\_\_\_\_\_\_ Glasses of Water/Day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Alcoholic Beverages? Y / N Avg. #/Week \_\_\_\_\_\_\_\_ Mostly What \_\_\_\_\_\_\_\_\_\_\_\_
Do you eat red meat Y / N Are you a Vegetarian? Y / N If so how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you dieting? Y N If so describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you eat in fast food restaurants? Y / N If so how many times a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
List of Nutritional Supplements you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Bowel movement frequency\_\_\_\_\_\_\_\_ Difficulty? Y / N How many times urinate/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you sleep well? Y / N If no describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have sufficient energy for normal activities? Y / N If no, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you wear corrective lenses? Y / N
Has your vision changed recently? Y / N Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you wear heel lifts or foot supports? Y / N Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**X-ray/MRI History**

|  |  |  |  |
| --- | --- | --- | --- |
| Age | Body Area | Type (normal x-ray, CAT, MRI, etc) | No. of Studies |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Family Medical History**
 Age Disease
Father \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Mother \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Siblings \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only: Menstrual History
Age at onset \_\_\_\_\_\_\_\_\_\_\_ Are your periods regular Y / N Cycle: \_\_\_\_\_\_\_\_days (start to finish)
Birth Control Y / N Your flow is: Heavy Medium Light Date of Last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you pregnant? Y / N How many months \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cramping? Y / N PMS? Y / N
Other Menstrual/Hormonal Symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Vaginal Infections? Y / N Miscarriage? Y / N

**Substance Survey Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription medications you are currently taking or have taken in the last year:

Medications Diagnosis

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product Symptom Quantity & Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year: (Use other side if needed)

Product Symptom Quantity & Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the following items which apply to you and indicate the amount of used:

Coffee \_\_\_\_\_\_ Artificial Sweeteners \_\_\_\_\_\_\_ Ice Cream \_\_\_\_\_
Tea \_\_\_\_\_\_ Antacids \_\_\_\_\_\_\_ Alcohol \_\_\_\_\_
Soft Drinks \_\_\_\_\_\_ Laxatives \_\_\_\_\_\_\_ Cigarettes \_\_\_\_\_
Diet soft drinks \_\_\_\_\_\_ Candy \_\_\_\_\_\_\_ Other tobacco products \_\_\_\_\_

How many desserts do you have in an average week? \_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA Consent Form**

Consent for Purpose of Treatment, Payment, and Healthcare Operations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the use or disclosure of my protected health information by **Perestam Chiropractic P.C.** the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Perestam Chiropractic P.C.** I understand that diagnosis or treatment of me by **Dr. Alan R. Perestam** may be conditioned up on my consent as evidenced by my signature on this document.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Perestam Chiropractic P.C.** is not required to agree to the restrictions that I may request. However, if **Perestam Chiropractic P.C.** agrees to a restriction that I request, the restriction is binding on **Perestam Chiropractic P.C.** and **Dr. Alan R. Perestam.**
I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr.** **Alan R. Perestam** or **Perestam Chiropractic P.C**. has taken action in reliance on this consent. My “protected health information” means health information, including my demographic information, collected from me and created to received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
I understand I have a right to review **Perestam Chiropractic P.C.** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Perestam Chiropractic P.C.** The Notice of Privacy Practices for **Perestam Chiropractic P.C.’s** duties with respect to my protected health information.
**Perestam Chiropractic P.C.** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by assessing the **Perestam Chiropractic P.C.** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority