

## **HIPAA NOTICE OF PRIVACY PRACTICES**

*Effective Date: 11.01.2013*

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

Jennifer Reardon, MS, RDN, CDN

47A Batavia City Centre

Batavia, NY 14020

585-250-0964

### **OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:**

I understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by Jennifer Reardon, MS, RDN, CDN, whether made by Jennifer Reardon, MS, RDN, CDN or your personal doctor.

This Notice will tell you about the ways in which I may use and disclose protected health information about you. I also describe your rights and certain obligations I have regarding the use and disclosure of protected health information. The law requires me to:

- make sure that protected health information (PHI) that identifies you is kept private;
- notify you about how I protect protected health information about you;
- explain how, when and why I use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that I maintain by:

- posting the revised Notice in my office

### **HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that I use and disclose protected health information without your written authorization.

**For Treatment.** I may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. I may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Nutrition By Design LLC personnel who are involved in taking care of you. Nutrition By Design LLC may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. I also may disclose protected health information about you to people outside Nutrition By Design LLC who may be involved in your medical care, such as clergy or others I use to provide services that are part of your care. I may use and disclose protected health information to contact you as a reminder that you have an appointment with Jennifer Reardon MS, RDN, CDN of Nutrition By Design LLC. I may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health related benefits or services that may be of interest to you.

**For Payment for Services.** I may use and disclose protected health information about you so that the

treatment and services you receive with Nutrition By Design LLC may be billed to and payment may be collected from you, an insurance company or a third party. For example, I may need to give your health plan or my billing company information about nutrition services you received with Nutrition By Design LLC so your health plan will pay me or reimburse you for the service. I may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations.** I may use and disclose protected health information about you for VIVE Nutrition health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care. For example, I may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. I may also combine protected health information about many Nutrition By Design LLC patients to decide what additional services VIVE Nutrition should offer, what services are not needed, and whether certain new treatments are effective. I may also disclose information to doctors, nurses, technicians, medical students, and other VIVE Nutrition personnel for review and learning purposes. I may also combine the protected health information I have with protected health information from other health care facilities to compare how I am doing and see where I can make improvements in the care and services I offer. I may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. I may also contact you as part of a fundraising effort. Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

**As Required By Law.** I will disclose protected health information (PHI) about you when required to do so by federal, state or local law.

**Research.** I may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Health Risks.** I may disclose protected health information about you to a government authority if I reasonably believe you are a victim of abuse, neglect or domestic violence. I will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and I believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or dispute, I may disclose your information in response to a court or administrative order. I 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 efforts have been made, either by me or by the requesting party, to tell you about the request or to obtain an order protecting the information requested.

**Business Associates.** I may disclose information to business associates who perform services on our behalf; however, I require them to appropriately safeguard your information.

**Public Health.** As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**To Avert a Serious Threat to Health or Safety.** I may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Health Oversight Activities.** I may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Law Enforcement.** I may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. I may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

**Organ and Tissue Donation.** If you are an organ donor, I may release protected 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.

**Special Government Functions.** If you are a member of the armed forces, I may release protected health information about you if it relates to military and veterans activities. I may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

**Coroners, Medical Examiners, and Funeral Directors.** I may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

**Correctional Institutions and Other Law Enforcement Custodial Situations.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

**Worker's Compensation.** I may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Food and Drug Administration.** I may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

## **YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES**

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

- I may share with a (family member, relative, friend or other) person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location, general condition

or death.

- I may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, I may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.

## **YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding protected health information I maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Nutrition By Design LLC. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other supplies associated with your request, and I will respond to your request no later than 30 days after receiving it. There are certain situations in which I am not required to comply with your request. In these circumstances, I will respond to you in writing, stating why I will not grant your request and describe any rights you may have to request a review of our denial.

**Right to Amend.** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to Nutrition By Design LLC. In addition, you must provide a reason that supports your request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:

- Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Nutrition By Design LLC;
- Is not part of the information which you would be permitted to inspect and copy; or
- I believe is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of protected health information about you. To request this list or accounting of disclosures, you must submit your request in writing to Nutrition By Design LLC. You may ask for disclosures made up to six years before your request (not including disclosures made before November 1, 2013). The first list you request within a 12-month period will be emailed to you for free. For additional lists, I may charge you for the costs of providing the list. I am required to provide a listing of all disclosures except the following:

- For your treatment.
- For billing and collection of payment for your treatment.
- For health care operations.
- Made to or request by you, or that you authorized.
- Occurring as a byproduct of permitted use and disclosures.
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates.
- As part of a limited data set of information that does not contain information identifying you.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information I use or disclose about you for treatment, payment or health care operations or to persons involved in your care. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5. To request restrictions, you must make your request in writing Nutrition By Design LLC.

**Right to Request Confidential Communications.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by email. To request confidential communications, you must make your request in writing to Nutrition By Design LLC. I will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. You may print this notice at any time for your records.

#### OTHER USES AND DISCLOSURES

I will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, I will stop using or disclosing your information, except to the extent that I have already taken action in reliance on the authorization.

#### YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Jennifer Turesky, MS, RD, CDN, CDE or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, I will not take any action against you or change our treatment of you in any way.

## **Informed Consent Regarding Email or the Internet Use of Protected Personal Information**

Nutrition By Design LLC provides patients the opportunity to communicate with health care providers and administrative staff by email. Transmitting confidential health information by email, however, has a number of risks, both general and specific, that should be considered.

### **1. Risks**

a. General email risks are the following: email can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an email; email is easier to falsify than handwritten or signed documents; backup copies of email may exist even after the sender or recipient has deleted his/her copy

b. Specific email risks are the following: email containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information: all individuals who have access to the protected information will have access to the email messages; patients who send or receive email from their place of employment risk having their employer read their email

2. It is the policy of Nutrition By Design LLC that all email messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such email messages or internet communications with the same degree of confidentiality as afforded by other portions of the protected personal health information. Nutrition By Design LLC will use reasonable means to protect the security and confidentiality of email or internet communication. Because of the risks outlined above, I cannot however guarantee the security and confidentiality of email or internet communications.

3. Patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

a. All emails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information of the patient. As a part of the protected personal health information, other individuals, such as VIVE Nutrition employees, other health care practitioners, insurance billers and upon written authorization, other health care providers and insurers will have access to email messages contained in protected personal health information.

b. Nutrition By Design LLC may forward email messages contained in protected personal health information. Nutrition By Design LLC will not, however forward the email outside the practice without the consent of the patient as required by law.

c. Nutrition By Design LLC will endeavor to read email promptly but can provide no assurance that the recipient of a particular email will read the message promptly. Therefore, email must not be used in a medical emergency.

d. It is the responsibility of the sender to determine whether the intended recipient received the email and when the recipient will respond.

e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, email should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases, such as syphilis, gonorrhea, herpes and the like; behavioral health, mental health or developmental disability; or alcohol or drug abuse.

f. Nutrition By Design LLC cannot guarantee that electronic communications will be private. However, I will take reasonable steps to protect the confidentiality of the email or internet communication but Nutrition By Design LLC is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.

g. If consent is given for the use of email, it is the responsibility of the patients to inform Nutrition By Design LLC of any types of information you do not want to be sent by email

h. It is the responsibility of the patient to protect their password or other means of access to email sent or received from Nutrition By Design LLC. Nutrition By Design LLC is not liable for breached of confidentiality caused by the patient. Any further use of email initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand my consent to the use of email may be withdrawn at any time by written communication to VIVE Nutrition.

I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all the risks associated with the use of email.

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Clients Name

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Date

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Signature

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### **Email and Text (SMS) Messaging Informed Consent**

In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when I communicate this way and to document that you are aware of these and agree to them. I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my e-mail communications with Nutrition By Design LLC will NOT be encrypted and, therefore, Nutrition By Design LLC can NOT guarantee the confidentiality and security of any information I send to her or that she sends to me via e-mail. I understand that SMS messages are even less secure than e-mail, and the same conditions apply. I understand that for this reason Nutrition By Design LLC has advised me not to send sensitive information via email or SMS message. This includes information about current or past symptoms, conditions, or treatment, identifying information such as social security numbers or insurance identification information. I hereby give permission for Nutrition By Design LLC to reply to my messages via e-mail, including any information that she deems appropriate, that would otherwise be considered confidential. I agree that Nutrition By Design LLC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet. I understand that Nutrition By Design LLC will limit SMS messages to brief inquiries or responses regarding scheduling. I understand that Nutrition By Design LLC may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail. I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that Nutrition By Design LLC has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use e-mail but will call Nutrition By Design LLC. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call Nutrition By Design LLC. I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible anyone given access to those records. I also understand that I may withdraw permission for Nutrition By Design LLC to communicate with me via e-mail or SMS by notifying Nutrition By Design LLC in writing.

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Clients Name

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Date

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Signature



## FINANCIAL CONSENT

I, \_\_\_\_\_, am choosing to enter into services with Nutrition By Design LLC. I understand that payment is due at the time that services are rendered. As my appointment time has been set aside for me.

I understand that Nutrition By Design LLC will bill my insurance company. If my insurance company denies payment I understand that my credit card will be billed for my visit with Nutrition By Design LLC.

**I understand that my credit card will be charged \$100 for an appointment not cancelled by telephone within 24 hours of scheduled appointment.**

### Credit Card Information

Client Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder Number: \_\_\_\_\_

Discover MC Visa American Express Last 3 digits from back of card \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_

My signature below signifies that I fully understand and agree with the above policies, and grant my permission to Nutrition By Design LLC to charge my credit card for any balance not paid for by my insurance company.

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (month/day/year)

Patient's Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ (month/day/year)

Insured's Address (if different from patient): \_\_\_\_\_

Insured's Place of Employment: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ OK to leave a message? Yes No

Work Phone: \_\_\_\_\_ OK to leave a message? Yes No

Home Phone: \_\_\_\_\_ OK to leave a message? Yes No

Email Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address (if not same as above): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ OK to leave a message? Yes No

Work Phone: \_\_\_\_\_ OK to leave a message? Yes No

Home Phone: \_\_\_\_\_ OK to leave a message? Yes No

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone(s): \_\_\_\_\_

\*\*Nutrition By Design LLC may share protected health information directly relevant to your care with:  
\_\_\_\_\_.

I acknowledge receiving an electronic copy of the following:

1. **HIPAA NOTICE OF PRIVACY PRACTICES**
2. **Informed Consent Regarding Email or the Internet Use of Protected Personal Information**
3. **Email and Text (SMS) Messaging Informed Consent**
4. **Financial Consent**

\_\_\_\_\_  
Clients Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Insured's ID Number: \_\_\_\_\_

Suffix: \_\_\_\_\_

Insured's Policy Group: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_