

Nutrition RS, LLC

Rita Singer, RD
Registered Dietitian
LIC#: 1011327
NPI#: 1518103027

353 Terhune Ave.
Passaic NJ, 07055
Phone: 862 239 6370
Fax: 973 521 5030

CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient Date of Birth: _____
(month/day/year)

I hereby consent to participating in nutrition counseling at Nutrition RS, LLC and understand that all information I provide is private, confidential, and protected by law as described in the Nutrition RS, LLC Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the Nutrition RS, LLC Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company: _____ **Primary Care Doctor:** _____

Doctor's Address: _____ **Doctor's Phone:** _____

Doctor's Fax _____

Parent (if applicable): _____ **Phone:** _____

Nutrition RS, LLC and its employees, staff and workers are hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Nutrition RS, LLC at the address above. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if under 18): _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

Effective date: January 14, 2013

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.

OUR LEGAL DUTY AND COMMITMENT TO PRIVACY

The dietitians and staff at Nutrition RS, LLC are and have always been committed to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act, known as HIPAA, we are now required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We provide each patient (and patient's parent, for patients under 18 years of age) with an authorization form to allow us to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

We are also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that we make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death.

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We may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request but if we do, you can obtain a review of that denial by another licensed health care professional that we designate. You also have the right to receive an “accounting”, which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests. If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information, or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than home. You may request that we restrict how we use or disclose information about you for treatment, payment or healthcare operations, or to persons involved in your care (except when specifically authorized by you, when required by law, or in emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them. To exercise any of the rights described above, please make a request in writing to Rita Singer, at the address above.

CHANGES IN OUR NOTICE OF PRIVACY PRACTICES

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices and post it in the waiting area of our office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of our Notices of Privacy Practices at any time.

COMPLAINTS

If you are concerned that we have violated your privacy rights, you may contact Rita Singer. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint.

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ACKNOWLEDGMENT OF RECEIPT OF NUTRITION RS, LLC PRIVACY PRACTICES

Please sign and return this page. You may keep the Notice of Privacy Practices for your records.

Patient Name _____ Date of Birth ____/____/____

Patient Home Address _____

Parent/Guardian Name (if patient is under 18) _____

I acknowledge receiving a copy of the Notice of Nutrition RS, LLC's Privacy Practices on
____/____/____.

PERMISSION TO LEAVE MESSAGES

I waive the usual permissions and protections of HIPPA for the convenience of contact by

- Phone (list numbers) _____
- Email (list address) _____

Please let us know how you heard of our services:

Patient Signature (or Parent/Guardian signature if patient is under 18)

For Nutrition RS, LLC use only.

If written acknowledgment was not obtained, please explain below: