HIPAA NOTICE OF PRIVACY PRACTICES - FINANCIAL RESPONSIBILITY - MEDICAL RECORDS RELEASE

NAME: _____ MRN: _____ DATE: _____

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.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:
Every Bite Counts®/Make Every Bite Count® (*EBC®/MEBC®*) understands that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all records of your care generated by the *EBC®/MEBC®* , whether made by *EBC®/MEBC®* personnel or your personal doctor. This Notice will tell you about the ways we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

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

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

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that we use and disclose protected health information without your written authorization. For Treatment. We may use protected health information about you to provide, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. *EBC®/MEBC®* staff 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. We also may disclose protected health information about you to people outside who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care. We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at *EBC®/MEBC®*. We 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: We may use and disclose protected health information about you so that the treatment and services you receive at *EBC®/MEBC®* may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at *EBC®/MEBC®* so your health plan will pay us or reimburse you for the service. We 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: We may use and disclose protected health information about you for 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, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many patients to decide what additional services the should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We 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. We 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: We will disclose protected health information about you when required to do so by federal, state or local law.
Research: We 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: We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We 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 we 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, we may disclose your information 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 efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.
Business Associates: We may disclose information to business associates who perform services on our behalf (such as billing companies); however, we require them to appropriately safeguard your information.
Public Health: As required by law, we 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: We 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: We 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: We 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. We 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, we 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, we may release protected health information about you if it relates to military and veterans activities. We 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: We 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. We 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, we 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: We 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: We 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.

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YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES:
Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

- We 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. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we 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 notify *EBC®/MEBC®* .

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU:
You have the following rights regarding protected health information we 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 *EBC®/MEBC®* . If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we 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 we have about you is incorrect or incomplete, you may ask us to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to *EBC®/MEBC®.* In addition, you must provide a reason that supports your request. We will act on your request for an amendment no later than 60 days after receiving the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, 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 *EBC®/MEBC®* ;
- Is not part of the information which you would be permitted to inspect and copy; or
- We 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 we made of protected health information about you. To request this list or accounting of disclosures, you must submit your request in writing to *EBC®/MEBC®* . You may ask for disclosures made up to six (6) years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are 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 we use or disclose about you for treatment, payment or health care operations or to persons involved in your care. We are not required to agree to your request. If we do agree, we 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 3-4. To request restrictions, you must make your request in writing to *EBC®/MEBC®* . .

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Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to *EBC®/MEBC®* . We 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 by contacting *EBC®/MEBC®* .

OTHER USES AND DISCLOSURES:
We 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, we will stop using or disclosing your information, except to the extent that we 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 the or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

CLIENT WRITTEN ACKNOWLEDGEMENT CONFIRMING RECEIPT OF PRIVACY NOTICE
I have received the *EBC®/MEBC®* HIPAA Privacy Notice.

Client name (print): _____ Date: _____

Client signature: _____

FINANCIAL RESPONSIBILITY NOTICE

I agree to be personally and fully responsible for payment of all non-covered charges related to any and all treatments provided by *EBC®/MEBC®*. I understand that charges resulting from this visit may not be filed with my insurance company. If these charges are filed and denied, the remaining balance will be billed directly to me. Furthermore, I am aware that insurance companies require *EBC®/MEBC®* to submit a diagnosis with each bill before they will approve payment for services. All diagnoses submitted to insurance companies will become part of my permanent insurance record.

Co-pay charges and appointment fees are required to be paid at the time of each appointment unless otherwise discussed. Cash, credit cards and personal checks are accepted. In the event that a check is returned for insufficient funds, I understand I will be charged $35.00 in addition to any bank charges incurred.

I also understand that I am responsible for charges that may result due to “no-show” appointments. These charges will equal the amount of an individual appointment. If I need to cancel an appointment, I will provide 24 hours notice and receive confirmation from the provider that the cancellation was received. Unless otherwise discussed, I understand late cancellation fees will be charged.

If I am unable to pay my remaining charges in full, I may be able to propose a payment plan to my provider. *This plan must be submitted in writing and approved before receiving treatment in order to be honored.

CLIENT WRITTEN ACKNOWLEDGEMENT CONFIRMING RECEIPT OF FINANCIAL RESPONSIBILITY NOTICE
I have received the *EBC®/MEBC®* Financial Responsibility Notice.

Client name (print): _____ Date: _____

Client signature: _____

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CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

AUTHORIZATION

I, _____, hereby consent to and authorize
(NAME OF PATIENT OR CLIENT)

_____
(NAME OF AGENCY, PHYSICIAN, HOSPITAL OR FACILITY)

_____
(ADDRESS OF AGENCY, PHYSICIAN, HOSPITAL OR FACILITY)

_____
(PHONE NUMBER, FAX NUMBER OF AGENCY, PHYSICIAN, HOSPITAL OR FACILITY)

to furnish to the requesting agent, *Every Bite Counts®/Make Every Bite Count®* (*EBC®/MEBC®*), medical records and information pertaining to medical history, services rendered, and/or treatment provided. This authorization is limited to the following medical records and types of information: nursing assessment and notes; physician orders and progress notes; treatment profile and records; social assessment; specialty evaluations; lab, radiology, and pathology reports; and case history.

DURATION: This authorization shall become effective immediately and shall remain in effect for three (3) years.

RESTRICTIONS: I understand that the requesting agent, *Every Bite Counts®/Make Every Bite Count®* (*EBC®/MEBC®*), may not further use or release the medical information unless an authorization is obtained from the patient or client or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes ( ) No ( ) Initials: _____

A photocopy or facsimile copy of this authorization shall have the same effect as the original.

Printed Name: _____ Date of Birth: _____

Signed: _____[SOF] Date: _____

If signed by other than the patient or client, indicate relationship: _____

Please fax medical records, lab reports, etc to *Every Bite Counts®/Make Every Bite Count®* (*EBC®/MEBC®*) at (336) 464-2891 (This is a secure, monitored fax.)