HIPAA Forms

B3yond Nutrition, LLC Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

B3yond Nutrition, LLC is required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions or want to know more about anything in this Notice, please contact:

B3yond Nutrition, LLC
Elizabeth A. Candela, MA, RDN, ACSM EP-C
Phone: 973-852-3335
Address: 2 Ardsley Rd, Glen Ridge, New Jersey 07028
Email: beth@beyondnutrition-rdn.com

B3yond Nutrition, LLC has engaged Elizabeth A Candela, MA, RDN, ACSM EP-C, a New Jersey State Certified Registered Dietitian Nutritionist to provide health care to clients. The information regarding the privacy practices in this notice will be followed by:

- Any health care professional or business associate with whom B3yond Nutrition shares health information.

B3yond Nutrition, LLC is committed to protecting medical information about you and creates a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all the records of your care that are maintained.

By law, B3yond Nutrition, LLC is required to:

- Keep medical information about you private.
- Give you this notice of legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that are currently in effect.

B3yond Nutrition, LLC may use and disclose medical information about you with your prior authorization for any purpose regarding your program, for example to improve your health care and to improve methods used for you in the program. B3yond Nutrition, LLC may use and disclose medical information about you without your prior authorization for several other reasons, subject to certain requirements:

- To report abuse or neglect
- Audits or inspections
- Worker's compensation purposes
- Emergencies

B3yond Nutrition, LLC may also disclose medical information when required by law (such as in response to valid judicial or administrative orders).

B3yond Nutrition, LLC also may contact you for appointment reminders, or tell you about or recommend possible options, alternatives, and/or health related benefits that may be of interest to you. B3yond Nutrition, LLC may disclose medical information about you to a close friend or family member who is involved with your medical care with. Your written authorization will be required before using or disclosing medical information about you in any other situation not covered by this notice. If you chose to authorize use or disclosure, you can later revoke that authorization by written notification of your decision to B3yond Nutrition, LLC.

HIPAA :

I. HIPAA Notice of Privacy:
B3yond Nutrition, LLC is required by law to maintain the privacy of protected health information, and provide individuals with this Notice of legal duties and privacy practices with respect to protected health information. If you have any questions, please speak in person or by phone with:
B3yond Nutrition, LLC
Elizabeth A. Candela, MA, RDN, ACSM EP-C
Phone: 973-852-3335
Address: 2 Ardsley Rd, Glen Ridge, New Jersey 07028

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of Privacy Practices.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. Authorization for use or Disclosure of Health Information:

- Patient Contact Information:

Home #:_____ Cell#: _____
Work#: _____Ext.____

I authorize messages with health information to be left on voicemail at (Check all that apply):
_____ Home _____ Cell _____ Work

I authorize secure electronic communication to be sent to my email address at:
_____

Restrictions/Instructions: _____

- Release of Health History and Treatment Information:

I authorize individual(s) to receive information regarding any billing issues and to act on my behalf: (Example: Spouse or Partner)

Name: _____ Relationship:_____

Name: _____ Relationship:_____

- Additional Authorizations:

Emergency Contact: _____

Relationship:_____

III. Patient Acknowledgement:
In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. My revocation will be effective once received by the practice, B3yond Nutrition, LLC
2. A copy of this authorization may be used with the same effectiveness as the original. This authorization replaces any prior authorization I have made regarding the use, release, and disclosure of health information:

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

By signing this document, I acknowledge that B3yond Nutrition, LLC has provided me with a copy of your Notice of Privacy Practices. The Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Policy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Policy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that B3yond Nutrition, LLC is not required to agree to my requested restrictions, but if you do agree you are bound by such restrictions.

___BY CHECKING HERE, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

___Check if you would like a copy of this agreement.

_____

Signature Date

Your Rights Regarding Personal Medical Information

- In most cases you have the right to look at or get a copy of medical information that I use to make decisions about your care, after submitting a written request. I may charge a fee for the cost of copying, mailing, or related supplies. If I deny your request to review or obtain a copy of your medical record, you may submit a written request for a review of that decision.
- If you think that information in your record is incomplete or incorrect you have the right to request that I correct the records by submitting a written request that I amend them. I would deny the request in cases when the information was not created by me, not part of the information maintained by me, or if I determine that the record was accurate. You may appeal in writing, a decision not to amend your record.
- You have the right to a listing of those instances where I have disclosed medical information about you, other than where you specifically authorized the disclosure. You must submit a written request stating the time period desired for the accounting, which must be less than a six-month period. The first disclosure list in a 12-month period is free. I will inform you before you incur charges for a subsequent list.
- You have a right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying me in writing.
- You may request in writing that I not use or disclose your medical information for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. I am not legally required to accept your request, but will consider it and inform you of my decision.
- If you are concerned that your privacy rights may have been violated, or you disagree with a decision I made about access to your records, you may send a written complaint to the U.S. Department of Human Services Office of Civil Rights. I will be happy to provide the address. Under no circumstances will you be retaliated against or penalized in any way.