Austin Functional Nutrition

Notice of Privacy Practices

Keeping a client’s personal health information secure is a top priority at my office. While information is the cornerstone of my ability to provide superior MNT services, the most important asset is client’s trust. This notice tells you how I collect, handle, and disclose personal health information about you. If you want to limit my disclosing of this information, please submit your wishes to me in writing.

My Policies and Practices to Protect Your Personal Health Information

I protect personal health information I collect about you by maintaining physical, electronic, and procedural safeguards that meet or exceed applicable law.

Protected Health Information I Collect and May Disclose

The protected health information I collect about you comes from the following sources:

* •  Information received from your physician or other healthcare provider.
* •  Information I receive from you while providing MNT services and on enrollment forms, assessment surveys, or other forms.
* •  Information I receive from other sources such as caregiver, insurer, employer and other third parties.

I may disclose any of your protected health information to the following entities as long as this information is directly related to health services or your individual care. These entities include doctors, hospitals, health care providers, pharmacies, insurance companies, family members or other persons involved directly in your individual care.

Your protected health information may be disclosed in the form of a “limited data set” for research, public health, and health care operations. A “limited data set” does not contain any direct identifiers of individuals (e.g. should not include name, address, phone number, social security number, medical number, etc.), but may contain any other demographic or health information needed for research public health or health care operations purposes.

I understand and acknowledge receipt of the above Notice of Privacy Practices. I also authorize the payment of medical and government benefits to the practitioner I saw for MNT Services received. I certify that I am financially responsible for all services this visit and all visits here after, rendered to me and/or members of my family if insurance or Medicare fails to assign payment or is not applicable

Signature Date

Printed Name Date

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