

## Consent and Statement of Financial Responsibility

### Delicious Nutrition - Telenutrition Services

I, the person signing below as Patient or Responsible Party, consent to have Delicious Nutrition, and its affiliates and subsidiaries' healthcare practitioner(s) ("Healthcare Practitioners") treat me, using telenutrition services. Telenutrition includes the practice of healthcare delivery, diagnosis, consultation, treatment, and education, using electronic communication. Benefits include but are not limited to: (1) I may not have to travel to a clinic location by utilizing telenutrition services; (2) care, treatment, or services may be more efficient and timelier, and (3) cost for treatment may be reduced. Potential risks include but are not limited to: (1) a possibility exists that communications or security could fail or (2) I may have to go use a different service in person. The electronic communications used for our telenutrition services includes security protocols and safeguards to protect the confidentiality and integrity of patient information and images.

I, on behalf of myself, consent to receive Patient care that may include (1) histories and questionnaires; (2) visual and physical assessment examinations; (3) diagnostic screening or testing; (4) treatment, wellness care, disease management, and counseling; and using video and audio technology to communicate with the Healthcare Practitioner. I consent and acknowledge that for all purposes that by signing below, I am the legally responsible party and that I am consenting to healthcare treatment for myself or consenting on behalf of a minor or other person, and that I verify that I am the parent, legal guardian, or personal representative of that person.

I have been informed about the limited services provided and that treatment will be performed by a Healthcare Practitioner who is a Registered Dietitian Nutritionist. I understand that Healthcare Practitioner(s) will only assess my nutrition, for a limited scope and number of health conditions, treatments, managements, and prescriptions. Any treatment will be in accordance with the Healthcare Practitioner's assessment, the result of any test(s) or screening(s) performed, nationally accepted best practices and clinical guidelines, any collaborative protocol(s), the licensure of the Healthcare Practitioner, and in accordance with all applicable law and regulations.

I acknowledge and agree that any nutrition diagnosis or test results may be sent to the email or address on my account as the Patient, or as the responsible party, and to my regular professional healthcare provider(s). A copy of my treatment documentation may be sent to any of my healthcare providers. The Healthcare Practitioner may contact my healthcare provider(s) to obtain medical information and discuss aspects of my treatment and progress in controlling my health condition and/or for a recommendation for further evaluation. Any other specific medical questions I have about my, or the Patient's health condition, treatment, or care should be discussed with the Patient's regular healthcare provider(s). All existing safeguards and laws regarding patient access to, and Delicious Nutrition's' use of, the Patient's medical information applies to these telenutrition services.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including federal healthcare beneficiaries, delinquent accounts shall bear interest at the legal rate allowed. We currently do not accept insurance payments. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect any outstanding balances on my account. Payment will be collected online before services are rendered. Current pricing is available at <https://delicious-nutrition.org/>

I acknowledge that I have received Delicious Nutrition Notice of Privacy Practices ("NOPP") and Patient Bill of Rights and Responsibilities. I confirm that I have read, or have had read to me, this form. I have had all questions related to this form answered and understand it.

Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Revised: 09/09/21

## NOTICE OF PRIVACY PRACTICES

### **I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW THIS INFORMATION IS ACCESSED.**

### **II. Angela Guenther, RDN (AG) AND ITS LEGAL NETWORK OF PROVIDERS HAVE A LEGAL DUTY TO SAFEGUARD *PROTECTED HEALTH INFORMATION (PHI)*.**

AG is legally required to protect the privacy of PHI, which includes information received that can be used to identify patients, their past, present, or future health or condition, the provision of health care, or the payment of this health care. AG "use" of PHI occurs when information is shared, examined, utilized, applied, or analyzed within the organization. PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of the organization. With some exceptions, no more PHI than is necessary to accomplish the purpose for which the use or disclosure is made may be used. AG is legally required to follow the privacy practices described in this Notice.

However, AG reserves the right to change the terms of this Notice and privacy policies at any time. Any changes will apply to PHI on file. Before any important changes to policies are made, this Notice will be changed and posted. A request for a copy of this Notice from AG may be made.

### **III. USE AND DISCLOSURE OF PHI**

AG may disclose your PHI for many different reasons. For some of these uses of disclosures, prior authorization is required; for others, it is not. Below are the different categories of uses and disclosures along with examples:

#### **A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations That Do Not Require Prior Written Consent.**

PHI can be used without consent for the following reasons:

1. For treatment. PHI may be disclosed to physicians and other licensed health care providers who provide health care services or are involved in patient care. For example, if you're being treated by a physician, AG can disclose PHI to that physician to coordinate your care.

2. To obtain payment for treatment. AG can use and disclose PHI to bill and collect payment for the treatment and services provided. For example, AG might send PHI to your insurance company or health plan to get paid for the health care services provided to you. AG may also provide PHI to third parties, such as billing companies, claims processing companies, and others that process health care claims. We currently do not accept insurance payments.

3. For health care operations. AG can disclose PHI in the normal course of business operation. For example, AG might use PHI to evaluate the quality of health care services that are received or to evaluate the performance of the health care professionals who provided such services. AG may also provide PHI to accountants, attorneys, consultants, and others to ensure that AG follows applicable laws.

4. Other disclosures. AG may also disclose PHI to others without consent in certain situations. For example, consent isn't required if to provide emergency treatment, if consent is obtained after treatment is rendered, or if the patient is unable to communicate (for example, unconscious or in severe pain) and would consent to such treatment if able to do so.

#### **B. Certain Uses and Disclosures Do Not Require Consent. PHI can be used without consent for the following reasons:**

1. When required by federal, state or local law; judicial or administrative proceedings; or law enforcement
2. For public health activities
3. For health oversight activities
4. For research purposes
5. To avoid harm
6. For specific government functions
7. For workers' compensation purposes
8. Appointment reminders and health related benefits or services

### **C. Certain Uses and Disclosures Require the Patient Have the Opportunity to Object**

#### **1. Disclosures to family, friends, or others**

**D. Other Uses and Disclosures Require Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, written authorization is required before using or disclosing PHI. If an authorization is signed to disclose PHI, it can be later revoked.

### **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

**A. The Right to Request Limits on Uses and Disclosures of PHI.** You have the right to ask that limits be placed on disclosure of PHI.

**B. The Right to Choose How PHI Is Sent to You:** You have the right to ask that information be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). AG must agree to such requests so long as the information can easily be provided in the format requested.

**C. The Right to See and Receive Copies of PHI.** In most cases, you have the right to look at or obtain copies of PHI in writing, with reasons for the denial and appeal procedure. Instead of providing the PHI requested, AG may provide a summary of or explanation of the PHI, if you agree to that.

**D. The Right to Get a List of the Disclosures.** Patients have a right to be provided a list of instances in which PHI has been disclosed. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. An accounting of disclosures will receive a response within 60 days of receiving your request. The list will include disclosures made in the last six years unless a shorter time is requested. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. More than one request in the same year will result in a reasonable cost-based fee for each additional request.

**E. The Right to Correct or Update PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request correction of the existing information or addition of the missing information. You must provide the request and your reason for the request in writing. AG will respond within 60 days of receiving your request to correct or update your PHI. Requests may be denied in writing if the PHI is (i) correct and complete, (ii) not created by AG, (iii) not allowed to be disclosed, or (iv) not part of AG records. Written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and AG's denial be attached to all future disclosures of PHI. Approved requests will result in changes to PHI.

**F. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

### **V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you think that privacy rights have been violated, or you disagree with a decision, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to The U.S. Department of Health and Human Services at [ocrportal.hhs.gov](http://ocrportal.hhs.gov)

### **VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE**

If you have any questions about this notice or any complaints about privacy practices, or would like to know how to file a complaint with The U.S. Department of Health and Human Services, please contact: Angela Guenther, RDN at [deliciousnutrition1@gmail.com](mailto:deliciousnutrition1@gmail.com)

**VII. EFFECTIVE DATE OF THIS NOTICE** This notice went into effect on October 21, 2021.