Notice of Privacy Practices

Update 02/03/2022

Keeping our participants personal health information secure is a top priority for us. While information is the cornerstone of our ability to provide superior Medical Nutrition Therapy (MNT), our most important asset is our client's trust. This notice tells you how we collect, handle, and disclose personal health information about you. If you want to limit our disclosing of this information, please submit your wishes to us in writing.

Our Policies and Practices to Protect Your Personal Health Information

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

Protected Health Information We Collect and May Disclose

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

- Information received from your physician or other healthcare providers.
- Information we receive from you while providing MNT services and on enrollment forms, assessment surveys, or other forms.
- Information we receive from other sources such as caregiver, health plan, employer and other third parties.

We may disclose any of your protected health information to the following entities if 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.

Protected health information will not be used for marketing, except if the communication is by a staff member is directly to you or to provide you with education or promotional material.

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.

Telehealth Consent: I consent to telehealth appointments. These may be conducted by videoconferencing or by telephone. I understand that the health care provider may ask for my weight, physical activity and other vitals over telehealth.

I understand that telehealth group sessions may be recorded for make-up purposes. If recorded, this media will be considered patient health information and stored in a secure manner.

No Show Fee: I will give at least 24 hours notice to change appointment. I understand that if I do not give at least 24 hours notice, to cancel or reschedule, I may be charged a $40 NO SHOW fee.

Photo Consent: I hereby give the permission to use my picture and I authorize the use and reproduction of it by Lifestyle Medicine Group, or anyone authorized by it. This includes any and all photographs which you have taken of me, for any purpose whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the sole property of Lifestyle Medicine Group.

Consent for payment: I understand and acknowledge receipt of this Notice of Privacy Practices. I also authorize the payment of medical and government benefits to Lifestyle Medicine Group for services received.

I Acknowledge these Privacy Practices

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