

NOTICE OF PRIVACY PRACTICES
 Susan Burke March, MS, RD, LD/N, CDE
 1090 Lambert Ave Flagler Beach, FL 32136
 386-439-2980

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Our practice is dedicated to maintaining the privacy of your personal health information. We are also required to do this by law. These laws are complicated, but we must provide you with important information. HIPAA is a set of federal regulations that grants rights and sets federal standards for privacy, security, and the sharing of all protected medical information.

Uses and Disclosure which do not require consent or authorization:

- Adult, child or domestic abuse
- Serious threat to health or safety
- Protective services (President and others)
- If a complaint is filed by the Florida Department of Health
- Judicial or administrative proceedings
- Worker’s compensation
- National security/intelligence activities

Your rights regarding your health information

- ▶ *Right to request restrictions on the release of information.* With your written consent, you may disclose protected health information (PHI) designating to whom; what types of information; for what purpose; and, for how long. You may revoke the release at any time or set certain restrictions.
- ▶ *Right to receive confidential communications by alternative means and at alternative locations.* You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment.
- ▶ *Right to inspect and copy.* You have the right to inspect health information we have about you such as your medical record. You can get a copy of these records if requested.
- ▶ *Right to Amend.* If you believe the information in your records is incorrect or incomplete, you can ask us to make changes (called amending) to your health information. You have to make this request in writing. You must tell us the reasons you want to make the changes.
- ▶ *Right to an accounting.* You have a right to an accounting of any disclosure of your PHI.
- ▶ *Right to a paper copy of this notice.* Upon your request, a copy will be provided.

Our duties regarding your health information

- ▶ Maintain the privacy of PHI.
- ▶ Reserve the right to change the policies and practices. If revised, you will be notified at your current address.

Questions or Complaints

If you believe your privacy rights have been violated and wish to file a complaint, send your written complaint to Susan Burke March, MS, RD, LD/N, CDE 1090 Lambert Ave Flagler Beach, FL 32136. Also, you can file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Filing a complaint will not change the health care we provide to you in any way. If you have any questions regarding this notice or our health information privacy policies, please contact the privacy officer, Susan Burke March at 386-439-2980.

Signature of client or guardian

Date

 Witness

 Date

Susan Burke March Registered Dietitian LLC

Behavioral Goals: Program Policies

Behavior Change: Treatment will focus on assisting you with nutrition knowledge, behavioral strategies, and cognitive restructuring in order to reach a desired health goal.

Length of Treatment: Depending on your stage of change, you may benefit from a few weekly sessions, or longer-term support.

Confidentiality Policy: All information shared in sessions will be held in confidence with the exception if it is believed that you may risk hurting her/himself or another person. If you are in treatment with a healthcare team, authorization to share information with other members of the treatment team will be necessary.

Cancellation: Except for circumstances beyond your control, cancellations are expected by phone or email at least 24 hours in advance of an appointment or you will be charged for the visit.

Availability: You may email me at any time with questions and I will attempt to get back to you within one day. I will attempt to provide you with at least a week's notice, to reschedule an existing appointment. Email to sburkerd@gmail.com

I, _____, have read and agree to the above policies on this _____(day) of _____(month) of 2009.

Signature

Date

Thank you for completing these two forms. Fax signed forms to 386-439-2980