

**RECONNECT WITH FOOD AT INNER DOOR CENTER,  
A DIVISION OF  
JUMP START CONSULTING, LLC  
NOTICE OF PRIVACY PRACTICES**

**NOTICE OF PRIVACY PRACTICES**

(Effective date: 1-10-03)

**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 LEGAL DUTY AND COMMITMENT TO PRIVACY**

We are committed to maintaining the privacy of your protected health information (“PHI”). We are required by law to maintain the privacy of your PHI, provide you with this Notice of Privacy Practices and notice of our legal duties regarding your PHI. We are also required to follow the practices described in our Notice of Privacy Practices currently in effect.

If you have any questions or complaints, please contact:

Privacy Official/Contact Person: BEVERLY PRICE, RD, MA, RYT

(Name): BEVERLY PRICE, RD, MA, RYT

(Addresses): Jump Start Consulting, LLC, 317 E. Eleven Mile Rd., Royal Oak, MI 48067

(Phone): (248) 336-2868

(E-mail): [Bev@reconnectwithfood.com](mailto:Bev@reconnectwithfood.com)

**USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (“TPO”)**

We may use or disclose PHI about you for our TPO, including for example:

- For treatment purposes (such as sharing information about your care with members of our staff to assist in your treatment or care, or with the physician or hospital that referred you to us, as part of efforts to coordinate your follow-up care),
- For payment purposes (such as verifying your insurance coverage or providing information needed for your health insurance plan to cover and pay for the claim for services that we provide to you)

- For health care operations (such as our administrative activities, activities to enhance the care that we provide to our patients and their satisfaction with our services, and activities to help make sure that we comply with applicable law).

We may also disclose your PHI for treatment activities of other health care providers, for payment activities of other health care providers, payors or health care clearinghouses, or for the health care operations of one of those entities if we and that entity each have (or had) a relationship with you and the PHI relates to that relationship.

### **OTHER USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION**

We may use or disclose PHI about you without your authorization for several other purposes required or permitted by law. Subject to certain requirements, we may use or disclose your PHI without your authorization as follows:

- to you upon request or as required by law;
- when required by the Secretary of the Department of Health and Human Services;
- for public health activities (such as reporting information to agencies authorized by law to collect information for purposes of preventing or controlling diseases, injuries or disabilities; preparing reports to the FDA; maintaining vital health records such as for births and deaths, etc.);
- to our business associates;
- to your personal representatives;
- for certain incidental uses or disclosures;
- for face to face communications that we make with you regarding products or services;
- to provide gifts of nominal value to you or your family;
- to correctional institutions if you are an inmate
- to help prevent or control communicable diseases;
- to your employer in limited circumstances, typically related to work place injuries or medical surveillance;
- for reporting abuse, neglect or domestic violence;
- for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc. );

- for judicial and administrative proceedings (such as in response to court orders or discovery requests);
- for law enforcement;
- to funeral directors, coroners and medical examiners;
- for purposes of organ, eye or tissue donation;
- to avoid a serious threat of harm to health and safety;
- for specialized governmental functions (e.g., military operations; national security);
- for auditing purposes;
- for certain research studies;
- for workers' compensation purposes; and
- for emergencies or disaster relief;
- to persons involved in your care or payment related to your care;
- for notification purposes with respect to your care, condition, location or death.

We may also contact you about appointment reminders, new programs that may benefit you, treatment alternatives or for fundraising purposes.

In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

## **INDIVIDUAL RIGHTS**

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request but if we do, you can obtain a review of that denial by another licensed health care professional that we designate.

You also have the right to receive an "accounting," which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment, or health care operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests.

If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than at home.

You may request that we restrict how we use or disclose information about you 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 emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them.

To exercise any of the rights described above, please make a request in writing to our Privacy Official/Contact Person listed on page one of this Notice.

### **CHANGES IN OUR NOTICE OF PRIVACY PRACTICES**

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices and post it in the waiting area of our office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You can request a copy of our Notice of Privacy Practices at any time. If this Notice of Privacy Practices was sent to you electronically, you have the right to obtain a paper copy upon request. For more information about our privacy practices, contact our Privacy Official/Contact person listed on the first page of this Notice.

### **COMPLAINTS**

If you are concerned that we have violated your privacy rights, you may contact the Privacy Official/Contact Person listed on the first page of this Notice. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
OF INNER DOOR CENTER, A DIVISION OF JUMP START CONSULTING,  
LLC**

**I acknowledge receiving a copy of the Notice of Privacy Practices of Reconnect with Food at Inner Door Center, a division of Jump Start Consulting, LLC on \_\_\_\_\_(insert date). Time: \_\_\_\_\_**

**Printed name of patient \_\_\_\_\_;**

**Printed name of authorized representative (if applicable) \_\_\_\_\_;**

**Signature or initials of patient or authorized representative \_\_\_\_\_;**

**Comments of Reconnect with Food at Inner Door Center, a division of Jump Start Consulting, LLC regarding why written acknowledgement was not obtained: \_\_\_\_\_**

\_\_\_\_\_

**This page of the Notice of Privacy Practices document needs to be completed and retained by Reconnect with Food at Inner Door Center, a division of Jump Start Consulting, LLC, in patient records.**

## **PATIENT AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION**

PLEASE READ CAREFULLY PRIOR TO SIGNING:

I give permission to Jump Start Consulting, LLC to

\_\_\_\_\_ use the following protected health information, and/or

\_\_\_\_\_ disclose the following health protected information to: Jump Start Consulting, LLC

FOR INTERNAL RESEARCH PURPOSES ONLY

which includes, but is not limited to, date of service, type of service provided, and referrals made to educational programs.

This protected health information is being used or disclosed in order to coordinate nutrition and health care provided with my treating medical professionals and to provide any information pertinent to my case for any insurance company, adjuster or attorney that may be potentially involved in my case. I agree to keep the staff of Jump Start Consulting, LLC, informed of any changes in my medical condition that would require change in nutrition or health education needed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jump Start Consulting, LLC, at the address above. I understand that a revocation is not effective to the extent that Jump Start Consulting, LLC, has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by Jump Start Consulting, LLC, will not condition my education program referral, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- ◆ Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ◆ Refuse to sign this authorization

Your signature indicates your understanding and acceptance of above policy and that you have received a copy of this agreement.

\_\_\_\_\_  
Signature of Patient or Personal Representative (and description)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time