HIPAA Information & Consent Form 2025

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). The restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPAA provides certain rights and protections to you as the patient. As your dietitian, I balanced these needs with the goal of providing you with quality professional care. Any additional information can be found at www.hhs.gov

1. Patient information will be kept confidential. Patient files may be stored in filing racks. Your records will never be left available to anyone other than staff. You agree to the normal procedures utilized within the office for the handling of charts, records and other documentation. You agree that the charts and records may be transported with the provider when handling assessments at the patients home.
2. It is the policy to remind the patient of their appointments. This will be done via text message or email. These will not contain any coding or content disclosing a patient's condition or information which is not already a matter of public record.
3. You understand and agree to the inspection of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
5. I agree to provide patients with access to their records in accordance with state and federal laws.

I, ______________________________________ date ______________________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Insurance

I understand that if my insurance information changes or is terminated, I will notify Jillian Foley or it could result in being billed for the services provided. I understand that if the insurance rejects the claim, it will be my responsibility.
Signature:__________________________________ Date: ________________________

Cancellation Policy

Jillian Foley is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. If unable to keep an appointment, please text or call 267-449-9733, 36 hours prior or you will be charged a $35 no-show fee.

Signature: ____