Debra Spector, MS, RD, CDN

Registered Dietitian, Nutritionist

150 Broadhollow Road
Suite #206
Melville, NY 11747
Phone: 631-864-6918
Fax: 631-499-0723
www.debraspector.com

NEW PATIENT FORMS/INFORMATION PACKET.

Thank you for choosing our office for your healthcare needs. Please bring the following items to your appointment:

1. Your **COMPLETED NEW PATIENT PAPERWORK**:

   - Complete and sign **NEW PATIENT REGISTRATION FORM**.
   - Complete both pages and sign **MEDICAL HISTORY FORM**.
   - Review STATEMENT OF OFFICE POLICIES. Please keep for your records.
   - Sign **ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES**.
   - Complete and sign **AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION**. (This allows our office to receive or send your records and/or speak with your therapist, medical doctor or other providers)

2. Your **COMPLETED HIPAA PAPERWORK**: (HIPPA or the Health Insurance Portability and Accountability Act enacted by the U.S. Congress in 1996, includes a privacy rule creating national standards to protect personal health information.)

   - Review NOTICE OF PRIVACY PRACTICES. Please keep for your records.
   - Sign **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**.
   - Complete and sign **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**.
   - Complete and sign **PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**.

3. Our policy states that you must bring your **INSURANCE CARD** to each visit, so that your insurance company will be billed correctly.

4. Most recent copy of complete blood work

5. For children & adolescents, a copy of **GROWTH RECORDS**.

6. **MEDICATION LIST** (including vitamins & herbs). Please include drug names and dosages. Note: if you have supplements that you would like me to evaluate, please bring to your first appointment as well.

Thank you for your time and patience in completing this paperwork. If you have any further questions, feel free to contact our office. We look forward to seeing you as a patient!

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NEW PATIENT REGISTRATION FORM

Patient's Legal Last Name:	**Legal First Name:**	**Middle:**		
Patient's Preferred Name:		**Marital Status**: (Check One) Single Mar Div Sep Wid		
Email Address:	**Social Security #:**	**Birth Date:**	**Age:**	**Sex:** M F
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )	**Preferred Contact:** Home Work Cell	
Mailing Address:	**City:**	**State:**	**Zip Code:**	
Referred to Clinic By: (please check one box): Family Friend Close to home/work Yellow Pages Web Site Insurance Plan Hospital Dr. _____ Other_____	**Family Members** seen by Debra Spector:			

PAYMENT & INSURANCE INFORMATION **Please present your insurance card at each visit**

Person Responsible for Bill: **(if different than patient)**	Social Security #:	Birth Date:		
Is this person a patient here? Yes No Is this person insured? Yes No	Home Phone: ( )	Cell or Work Phone: ( )		
Patient's Relationship to this person: Spouse Child Other				
Mailing Address: (if different than patient)	City:	State:	Zip Code:	

PRIMARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to
Subscriber's Name: (if different than patient)			Subscriber's S.S. #:	Subscriber's Birth Date:
Patient's Relationship to Subscriber: Self Spouse Child Other				

SECONDARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to
Subscriber's Name: (if different than patient)			Subscriber's S.S. #:	Subscriber's Birth Date:
Patient's Relationship to Subscriber: Self Spouse Child Other				

CONTACT IN CASE OF EMERGENCY

Name:	Home Phone: ( )
Relationship to Patient:	Cell or Work Phone: ( )

The above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Debra Spector, MS, RD, CDN. I understand that I am financially responsible for any balance. I authorize Debra Spector, MS, RD, CDN or insurance company to release any information required to process my claims.

Patient or Guardian Signature **Date**

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PATIENT MEDICAL HISTORY FORM

Birth Date:_____ Today's Date:_____

Last Name:_____First:_____Middle:_____

Occupation: _____

Current Physician: _____

Previous Physician: _____

Therapist: _____

Psychiatrist: _____

Other Provider: _____

PATIENT CONDITIONS [Circle all that apply]

FAMILY HISTORY Complete all that apply

Family Member:	Medical Conditions or Cause of Death
Father	
Mother	
Grandparents (Mom) Number _____	
Grandparents (Dad) Number _____	
Children Number _____	

CURRENT MEDICATIONS (INCLUDE VITAMINS, HERBS, OVER THE COUNTER MEDICATIONS, ASPIRIN,MEDICATIONS FOR HEART, CHOLESTEROL, BLOOD PRESSURE, PAIN, THYROID, BIRTH CONTROL, DIET, ETC.)

FOOD/MEDICAL ALLERGIES:

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PLEASE CHECK ANY CURRENT OR RECENT (Within 90 days) SYMPTOMS OR COMPLAINTS AND/ OR WRITE IN ANY OTHER SYMPTOMS OR COMPLAINTS

GENERAL HEALTH	FATIGUE	WEAKNESS	WEIGHT PROBLEMS
HEENT	HEADACHES	HEARING PROBLEMS	EAR RINGING
	HOARSENESS	EYE PROBLEMS	SINUS PROBLEMS
RESPIRATORY	COUGHING	COUGH UP BLOOD	SHORTNESS OF BREATH
	WHEEZING	PLEURISY	ASTHMA
CARDIAC	CHEST PAIN OR TIGHTNESS	HEART MURMUR	PALPITATIONS
	HEART DISEASE THAT LIMITS ACTIVITY	ANGIOPLASTY (STENTS)	HYPERLIPIDEMIA
MUSCULOSKELETAL	ARTHRITIS OR JOINT PAIN	GOUT	BACK PAIN
	BURSITIS	TENDONITIS	
GENITOURINARY	BLADDER OR KIDNEY INFECTIONS OR PROBLEMS	KIDNEY STONES	DIFFICULTY / PAINFUL URINATION
	BLOOD OR PROTEIN IN URINE	PROSTATE PROBLEMS	
ENDOCRINOLOGY	DIABETES W/ INSULIN	DIABETES W/ MEDICATION	DIABETES W/ LIFESTYLE CHG
	HYPERTHYROIDISM	HYPOTHYROIDISM	P C O S
OTHER	SKIN PROBLEMS	FOOD ALLERGIES	ANEMIA
	BLOOD DISEASE		
GYN - FOR WOMEN ONLY			
AGE MENSTRUATION STARTED: _____	PERIOD EVERY_____DAYS	LAST MENSTRUAL CYCLE: _____	MENSTRUATING NOW? _____
HEAVY PERIODS	IRREGULAR	SPOTTING / DISCHARGE	VAGINAL PROBLEMS
# PREGNANCIES: _____	TYPE OF BIRTH CONTROL USED: _____		

_____ _____

Signature of Patient (or Guardian) **Date**

STATEMENT OF OFFICE POLICIES

Thank you for choosing the office of Debra Spector for your healthcare needs. We provide the highest standard of patient care in a convenient and cost-effective manner. Ms. Spector is a licensed and certified Registered Dietitian and Nutritionist. She has been in practice on Long Island since 1990. We take your healthcare seriously and look forward to working with you to improve and maintain your health.

Please sign the attached Acknowledgment of Receipt of Office Policies Form and return it to my office during your next visit. You may keep this copy of Office Policies for your records.

APPOINTMENTS

Normal offices hours are Tuesdays & Wednesdays: 9 a.m. to 8 p.m.; Thursdays & Fridays: 9 a.m. – 2:30 p.m. and every other Saturday.

Our normal offices hours in Melville are Tuesdays & Wednesdays 9am to 8pm and Telehealth

I will make every attempt to stay on schedule and see you in a timely manner. However, due to unforeseen patient emergencies, I sometimes have delays. Be assured that I will spend the necessary time and attention at every visit to ensure your high quality care. I will always address the primary reason for your appointment, but you may be required to make additional appointments to address additional concerns.

If I'm unavailable due to scheduling, vacation, or absence, every attempt will be made for you to schedule your next appointment accordingly.

FEES, PAYMENT & INSURANCE

My fees are standard and comparable to other Registered Dietitians. **Payment for office visits is expected at the time of service**. Insured patients are responsible for their percentage, deductible and/or co-pay at time of visit. **We accept cash & personal checks. There is a $35 late payment fee for returned checks.**

I am contracted with some insurance companies. This simply means that I has agreed to provide healthcare services at a negotiated rate, and that my office will file the insurance claim for you. **It is YOUR responsibility to provide accurate, updated information, so that we may file a correct and accurate claim. For this reason, you are required to present your insurance card at the time of every visit, and complete a new patient information form on an annual basis.** Failure to do so can delay payment by your insurance company. You must promptly provide your insurance company with any information they request to process pending claims. Do not ignore a letter from your insurance company or from our office. If payment is not received from your insurance company within 60 days of the claim, you are responsible for the balance.

As the patient, you are ultimately responsible for payment of services I've provided.

CANCELLATION POLICY

We prefer that you contact our office at least 24 hours prior to your scheduled appointment if you must cancel or reschedule. We allow one emergency visit per year. If you do not give our office 24 hours notice you can opt for a phone session or you will be charged in full.

REFERRALS

If your insurance plan requires that you obtain a referral in order to see a specialist, please call our office at least one week prior to your scheduled appointment, so that we can process your referral. **It is your responsibility to verify that Debra is a participant with your insurance plan and she has received your referral.**

PHONE MESSAGES

You can leave a message. Be rest assured that I will return the call when I am in the office and not with patients. Text messages will not be returned.

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ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICIES

I acknowledge that I have received and reviewed a copy of the office policies for the office of Debra Spector, MS, RD, CDN

_____ _____

Signature Date

_____ _____

Name Printed Phone Number

Debra Spector, MS, RD, CDN

Registered Dietitian, Nutritionist

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AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ **DOB:** _____

Phone #: _____ **SS #:** _____

Address: _____

_____

_____

I authorize records: (please select one)

[ ] To be released **TO** Debra Spector, MS, RD, CDN from

_____

Address: _____

Phone: _____Fax: _____

[ ] To be released **FROM** Debra Spector, MS, RD, CDN to

_____

Address: _____

Phone: _____Fax: _____

This authorization gives Debra Spector, MS, RD, CDN permission to request your medical records from any health care provider, including therapists and Psychiatrist, that you have received treatment from as specified above for the duration that you have a direct treatment relationship with Debra Spector, MS, RD, CDN. Debra Spector, MS, RD, CDN is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws & regulations.

_____ _____

Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

_____ _____

Relationship to patient or Legal Representative Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected. Laws & regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully**

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your **individually identifiable health information (also called protected health information, or HIPAA**). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your HIPAA. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose HIPAA information, Your privacy rights concerning HIPAA and our obligation concerning use & disclosure of HIPAA:

The terms of this notice apply to all records containing your HIPAA that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Debra Spector, MS, RD, CDN (631-864-6918) at the address above

We may use and disclose your HIPAA in the following ways:

The following categories describe the different ways in which we may use and disclose your HIPAA.

1. **Treatment**. Our practice may use your HIPAA to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. My practice may use or disclose your HIPAA in order to treat you or to assist others in your treatment. Additionally, we may disclose your HIPAA to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your HIPAA to other health care providers for purposes related to your treatment.

2. **Payment**. Our practice may use and disclose your HIPAA in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your HIPAA to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your HIPAA to bill you directly for services and items. We may disclose your HIPAA to other health care providers and entities to assist in their billing and collection efforts.

3. **Health care operations**. Our practice may use and disclose your HIPAA to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your HIPAA to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your HIPAA to other health care providers and entities to assist in their health care operations.

4. **Appointment reminders.** Our practice may use and disclose your HIPAA to contact you and remind you of an appointment.

5. **Treatment options.** Our practice may use and disclose your HIPAA to inform you of potential treatment

options or alternatives.

6. **Health-related benefits and services.** Our practice may use and disclose your HIPAA to inform you of health-related benefits or services that may be of interest to you.

7. **Release of information to family/friends.** Our practice may release your HIPAA to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. **Disclosures required by law**. Our practice will use and disclose your HIPAA when we are required to do so by federal, state or local law.

C. Use and disclosure of your HIPPA information under special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks**. Our practice may disclose your HIPAA to public health authorities that are authorized by law to collect information for the purpose of:

   - Maintaining vital records, such as births and deaths,
   - Reporting child abuse or neglect,
   - Preventing or controlling disease, injury or disability,
   - Notifying a person regarding potential exposure to a communicable disease,
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
   - Reporting reactions to drugs or problems with products or devices,
   - Notifying individuals if a product or device they may be using has been recalled,
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health oversight activities**. Our practice may disclose your HIPAA to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and similar proceedings**. Our practice may use and disclose your HIPAA in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your HIPAA in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law enforcement**. We may release HIPAA if asked to do so by a law enforcement official:

   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
   - Concerning a death we believe has resulted from criminal conduct,
   - Regarding criminal conduct at our offices,
   - In response to a warrant, summons, court order, subpoena or similar legal process,
   - To identify/locate a suspect, material witness, fugitive or missing person,
   - In an emergency, to report a crime (including location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Deceased patients.** Our practice may release HIPAA to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and tissue donation.** Our practice may release your HIPAA to organizations that

handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your HIPAA for research purposes in certain limited circumstances. We will obtain your written authorization to use your HIPAA for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

   (A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the HIPAA will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

   (B) The research could not practicably be conducted without the waiver

   (C) The research could not practicably be conducted without access to and use of the HIPAA.

8. **Serious threats to health or safety**. Our practice may use and disclose your HIPAA when necessary to reduce or prevent a serious threat to your health and safety or that of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military**. Our practice may disclose your HIPAA if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National security**. Our practice may disclose your HIPAA to federal officials for intelligence and national security activities authorized by law. We also may disclose your HIPAA to federal and national security activities authorized by law. We also may disclose your HIPAA to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. **Workers' compensation**. Our practice may release your HIPAA for workers' compensation and similar programs.

E. Your rights regarding HIPAA

You have the following rights regarding the HIPAA that we maintain about you:

1. **Confidential communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Debra Spector specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting restrictions**. You have the right to request a restriction in our use or disclosure of your HIPAA for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your HIPAA to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your HIPAA, you must make your request in writing to Debra Spector. Your request must describe in a clear and concise fashion:

   - The information you wish restricted,
   - Whether you are requesting to limit our practice's use, disclosure or both,
   - To whom you want the limits to apply.

3. **Inspection and copies**. You have the right to inspect and obtain a copy of the HIPAA that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Debra Spector in order to inspect and/or obtain a copy of your HIPAA. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Debra Spector. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the HIPAA kept by or for the practice; (c) not part of the HIPAA which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your HIPAA for purposes not related to treatment, payment or operations. Use of your HIPAA as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Debra Spector. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

5. **Right to a paper copy of this notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Ms. Spector's office.

6. **Right to file a complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Debra Spector, MS, RD, CDN (631-864-6918) at the above address. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

7. **Right to provide an authorization for other uses and disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your HIPAA may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your HIPAA for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Debra Spector, MS, RD, CDN(631-864-6918) at the above address.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed the Notice of Privacy Practices for the office of Debra Spector, MS, RD, CDN

[ ] I decline the right to receive a personal copy at this time, being aware that I may request a copy at a later date.

_____ _____

Signature of Patient **Date**

OR

[ ] I choose the right to receive a personal copy of the policies

_____ _____

Signature of Patient **Date**

For Office Use Only:
Disclosure of HIPAA Log

Date	Description of Disclosure	Description of HIPAA	Who Requested	To Whom Disclosed	Approve or Deny	Reason Comments

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Registered Dietitian, Nutritionist

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

**(This form gives permission to contact you via mail, phone or email)

I hereby give my consent for Debra Spector (including office staff) to use and disclose protected health information (HIPAA) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Ms. Spector describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ms. Spector reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the address above.

With this consent, Ms. Spector **may call my home or other alternative number and leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Ms. Spector **may mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Ms. Spector **may e-mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Ms. Spector restrict how it uses or discloses my HIPAA to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Ms. Spector (including office staff) to use and disclose protected health information (HIPAA) about me to carry out treatment, payment and health care operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ms. Spector may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

Debra Spector, MS, RD, CDN

Registered Dietitian, Nutritionist

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Please circle any of the foods you eat on a regular basis. Underline the foods you eat once in awhile.

MEATS	EGGS	SAUSAGE	COLD CUTS	FRANKFURTERS
	HAMBURGERS	PIZZA	BEEF	CHICKEN
	FISH	LOBSTER	TURKEY	RIBS
BREADS & GRAINS	ROLLS	DANISH	CRACKERS	DOUGHNUTS
	MUFFINS	PRETZELS	POPCORN	WAFFLES
	COOKIES	RICE	MACARONI	CAKE
	CEREAL	PANCAKES	BAGELS	
DAIRY	WHOLE MILK	LOW-FAT MILK	1% MILK	SKIM MILK
	ICE CREAM	FROZEN YOGURT	SHERBET	YOGURT
	LOW-FAT YOGURT			
FATS	BUTTER	VEGETABLE OIL	CREAM CHEESE	GRAVY
	MAYONNAISE	OLIVES	TURKEY/CHICKEN SKIN	MARGARINE
	SOUR CREAM	BACON	PEANUTS	
VEGETABLES	GREEN BEANS	CARROTS	PEPPERS	TOMATO
	CAULIFLOWER	POTATO	BROCCOLI	CORN
	LETTUCE	ONIONS	YAMS	
FRUITS	BANANA	KIWI	PLUM	PAPAYA
	APRICOT	CANTALOUPE	STRAWBERRIES	WATERMELON
	APPLE	GRAPES		
SWEETS	CANDY	JAM	COCONUT	CHOCOLATE
	SYRUP	PUDDING		
DESSERTS	BROWNIES	APPLE PIE	JELL-O	RICE PUDDING
	CHEESECAKE	FRUIT CUP	CHOCOLATE CAKE	
BEVERAGES	COLA DRINKS	TEA	JUICES	
	COFFEE	SELTZER	WATER	
ALCOHOL	BEER	WINE	RUM	VODKA
	MARTINIS			
CONDIMENTS	MUSTARD	SALT	RELISH	CATSUP
	SALAD DRESSING			

Debra Spector, MS, RD, CDN

Registered Dietitian, Nutritionist

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

****(This form gives permission to share certain patient health information with the people listed below)**

By signing, I authorize Ms. Spector to use and/or disclose certain protected health information (HIPAA) about me to the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

This authorization permits Ms. Spector to use and/or disclose protected health information about me (such as dates of services, type of services, lab and test results, prescription information, recommendations of treatment, etc.). The following is excluded from this authorization.

I have the right to refuse to sign this authorization. I do not have to sign this authorization in order to receive treatment from Ms. Spector. When my information is used or disclosed pursuant to this authorization, it may be subject to re- disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This authorization is in effect until revoked in writing by patient. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Debra Spector, MS, RD, CDN
150 Broadhollow Road, Suite 206
Melville, NY 11747

Signed by:

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patient's Name	Effective Date

Print Name of Patient or Legal Guardian (if applicable)