Janai Meyer Nutrition & Lactation, LLC

Provider: Janai Meyer RDN, LD, IBCLC

25 Jefferson Way Suite 101B Ketchikan, AK 99901

INFORMED CONSENT and HIPAA NOTIFICATION for TREATMENT

Patient Name_____ Date of Birth_____

I give my consent for treatment from Janai Meyer Nutrition and Lactation, LLC to myself and/or my child.

I give my consent for Janai Meyer Nutrition and Lactation, LLC to release any information required in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, and/or our insurance company upon request. I understand that Janai Meyer Nutrition and Lactation, LLC may contact my physician or primary care provider if she feels it is necessary to consult with them.

I acknowledge that the office Janai Meyer Nutrition and Lactation, LLC as a courtesy, will be submitting my services for insurance and/or billing. I am responsible for all charges regardless of insurance coverage and/or payments.

I understand that for all consults the office of Janai Meyer Nutrition and Lactation, LLC will protect the privacy of my personal health information as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA). Per Federal Regulations, this notice went into effect on April 14, 2003

It is essential that clients in attendance at this location, and those visiting the location, understand the importance of safeguarding the confidentiality and anonymity of others who are seen on the premises. The undersigned agrees not to divulge, publish or otherwise make known to any unauthorized third party, orally or in writing, any information obtained from or on behalf of another client. The undersigned also acknowledges receipt, review, and understanding his/her rights, and exceptions, related to Confidentiality of client records & information. **The clinician will display and make available in office and online a copy of the HIPAA Policy.**

I have read, understand and agree to the above.

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Jmm 2019

Patient or Guardian Signature Date