Healthy Living Dallas

HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: June 3, 2014

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who is involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health

information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Appointments and Services: We may use your personal health information to remind you about appointments or to follow up on your visit.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: *We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures*

Public Health: *We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.*

Communicable Diseases: *We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.*

Health Oversight: *We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.*

Food and Drug Administration*: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.*

Legal Proceedings: *We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.*

Research: *We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.*

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: *Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.*

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

To request access: To inspect or obtain copies, you must sign an authorization form, allowing us to release this information to you. If you request copies of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain, very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Healthy Living Dallas will review your request and the denial. The person conducting the review will not be the person who denied your request.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

A list of these patient's rights shall be posted in English within the facility so that such rights may be read by the patients.

Organizational Ethics:

Healthy Living Dallas operates under a Code of Conduct. The purpose of this Code of Conduct is to ensure that all members of Healthy Living Dallas are committed to conducting their activities in accordance with the highest levels of business ethics, and in compliance with all applicable state and federal laws and regulations.

Patient Responsibilities:

The care a patient receives depends on the patient himself/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect.

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health including existing level of pain.
- The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment, and what is expected of him/her.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses, and other health professionals, as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient may not record conversations with the physician via audio and/or video without the physicians consent. If the patient chooses to record via audio/video, they will have to sign a consent form.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and facility personnel, which includes refraining from use of foul language and abusive, threatening, or disruptive behavior.

HIPAA **Notice of Privacy Practices,** ***Patient's Rights, Responsibilities, & Organizational Ethics***

I am aware of the HIPAA Notice of Privacy Practices for Healthy Living Dallas. The copies of the notice are available for me to take upon request.
I have the right to request a copy of the Patient's Rights, Responsibilities, & Organizational Ethics at any time.

_____ _____

Print Patient Name **Date of Birth**

_____ _____

Signature of Patient or Parent/Guardian **Date**

Initial here:

_____**Medical Records:** If you should request a copy of your medical records, a $25.00 fee will be assessed for the first twenty pages, and $.50 for each additional page. *(Texas Medical Board Rules §165.2)*

Healthy Living Dallas

Patient Authorization for Use/Disclosure of Health Information

Uses and Disclosures of Protected Health Information

I understand that as part of my healthcare, Healthy Living Dallas originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations.

Healthy Living Dallas *Notice of Privacy Practices* provides specific information and complete description of how my personal health information (PHI) may be used and disclosed. I have been provided a copy of *Notice of Privacy Practices,* effective June 3, 2014 and understand that I have the right to review the notice prior to signing this authorization. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payments or healthcare operations and that Healthy Living Dallas is not required to agree to the restrictions requested. I may revoke this authorization at any time in writing except to the extent that Healthy Living Dallas has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list family members or other persons, if any, whom may inquire and/or be informed about your general medical concerns/condition/diagnosis:

Name:_____ Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Other restrictions on the use/or disclosure of my personal health information:

_____

_____

Signature of Patient:_____ Date:_____

Printed Name:_____

In general the HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of their protected information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Healthy Living Dallas

In the event that Healthy Living Dallas needs to contact you with medical information we will first attempt to contact you by phone with the numbers provided below. Please specify if detailed messages are allowed with each phone number provided or if a call back number only is requested. Please be aware that even if a call back number only is requested we will still identify ourselves by our name and the name of our practice when leaving a voicemail. If we are unable to contact you within three phone attempts we will mail your pertinent healthcare information to your mailing address listed below. Please be aware that when mail communication is sent that persons other than yourself may have access to it in transit or upon arrival at the address listed below. Healthy Living Dallas guarantees the protection of your personal health information within the walls of our facility but cannot guarantee this safety outside of the office environment.

Phone Communication:

Preferred Number: (_____)_____ **Secondary Number:** (_____)_____

□ OK to leave detailed message
□ Leave message with call back number only

□ OK to leave detailed message
□ Leave message with call back number only

Preferred Address for Written Communication:

Address: _____

City _____ State _____ Zip Code: _____

By signing this document I agree to the communication terms listed above.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____ Date of Birth: _____

Healthy Living Dallas

Patient Consent for Use of Email / Text Communication

(Complete this section ONLY if you wish to receive email communication)

The turnaround time for routine patient communications is approximately 2 business days. However, this estimated response time could be longer due to technical problems, office closings, internet service provider delays, patient volume, or staff absence. Should you require urgent or immediate attention, this medium is not appropriate.

- You may send general questions; communicate billing questions, and many other items. Of course, you may also continue to contact us via phone and postal mail.
- This authorization is not a promise that all of the above noted communications will occur through our portal, as there may be multiple circumstances where we will need to speak with you on the phone or in person.
- There should be no expectation of bi-directional email communications between you and your provider but your provider will be made aware of your portal communications as needed.

We need your email to provide this service but please do not provide us with business email addresses. Business emails are not typically private. Please also provide us with your cell number which may allow you to also receive a text message when a message has been sent to your portal account.

When sending an email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your first and last name, date-of-birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature. Please do not use abbreviations in email communication.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, access to your email may not be well controlled, so you should take that into consideration. In addition, you should be aware that staff will have access to any information addressed specifically to the physician.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to factors beyond this office's control. *I understand that communications relating to diagnosis and treatment will be filed in my medical record.*

By signing below, you are agreeing to the above email/text policy and that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Signature of Patient	Printed Name	Date
		( )
Email		Preferred Cell Phone Number

Healthy Living Dallas

CANCELLATION, LATE ARRIVAL & MISSED APPOINTMENT POLICY

A therapeutic relationship is built on mutual trust and respect. Every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call when you are unable to keep your appointment or will arrive late. Please read, sign, and date the cancellation, late arrival & missed appointment policy below.

1. If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 24 hours in advance. At the time of cancellation, another appointment will be offered to you that may work better for your schedule.
2. Patients will be considered late if they check-in 15 minutes late for a new patient appointment or 10 minutes late for follow-up appointments and may be asked to reschedule their appointment to allow adequate time to spend with you and other scheduled patients. Patients checking-in more than 30 minutes late for a new patient appointment or more than 15 minutes late for a follow-up appointment will be marked as missed appointments and appropriate fees may apply.
3. If you fail to notify the office of your cancellation within the time stated above, and miss your scheduled appointment, an administrative fee will be charged. This will result in a non-refund of new patient appointment deposits or a fee of **$25.00** for any follow up visit. This administrative fee must be paid prior to scheduling future visits.
4. Three (3) missed appointments – they need not be consecutive – can result in an administrative discharge from the practice.
5. To cancel or reschedule appointments or to notify staff of late arrival please contact our office via phone. Email or faxed appointment cancellations are not acceptable.

Patient Initials: _____

INFORMATION REGARDING THE USE OF PHOTOGRAPHS, VIDEO & AUDIO RECORDING

It is the policy of Healthy Living Dallas to protect the privacy and confidentiality of all patient information, including the patient's Protected Health Information (PHI), in accordance with applicable state and federal laws and ethical standards. Healthy Living Dallas prohibits persons not authorized by law to photograph, videotape, audiotape, audio record from a cell phone and/or other device while the patient is consulting with the physician.

When the friends and family are involved in a patient's care, and request physicians at Healthy Living Dallas to take photographs, videotape, audiotape, audio record from a cell phone and/or other device, solely for personal use, the patient is required to notify the receptionist. It is at the discretion of the physician to approve or deny this request. If approved, the patient will be required to sign an additional consent form

This consent will be a separate written form from the patient HIPAA Privacy Practices. Healthy Living Dallas may disclose to law enforcement officials if Healthy Living Dallas believes in good faith that this policy has been violated and will disclose evidence of criminal conduct that occurred on the premises of Healthy Living Dallas.

I have read and understand the Cancellation, Late Arrival, & Missed Appointment Policy of Healthy Living Dallas as well as the Information Regarding the Use of Photographs, Video & Audio Recording. By signing this agreement I agree with the terms listed in both of these policies as listed above.

Print Name: _____

Patient Signature: _____ Date: _____

Healthy Living Dallas

FINANCIAL POLICY

We would like to thank you for choosing us as your medical provider. Because we are committed to providing you with the best possible care and service, we would like to make you aware of our financial policy. We require that you read and sign this document prior to receiving medical treatment.

Copayments, Deductibles, and Fees: Your insurance carrier requires that we collect your co-pay at the time of service. Deductibles and fees for services not covered by your insurance are also due at the time service is rendered. We accept cash, checks, VISA, MasterCard, and Discover. A $35.00 fee will be assessed to your account if a check is returned for non-sufficient funds.

Insurance: You must present a current insurance card at each visit and all pertinent information required. If you do not present a current insurance card, you will be responsible for payment in full at the time of service. Your medical insurance is a contract between you and your insurance company. We will assist in filing your insurance claim, but you are primarily responsible for any charges incurred while you are a patient. If your insurance carrier is not one that we participate with, you are responsible for payment in full at the time of service. You have a responsibility to provide timely information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If the claim is paid at a later date, you will be reimbursed by Healthy Living Dallas.

Missed Appointments: We may charge a $25.00 "no show" fee if you fail to keep a scheduled appointment or fail to cancel an appointment without at least 24-48 hour notice. Please refer back to the Cancellation, Late Arrival, & Missed Appointment Policy for further descriptions of missed appointments. This fee is not covered by your insurance plan and is your responsibility. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.

Prompt Payment: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, please contact our billing office prior to your appointment to discuss payment options. If you have a past due balance on your account, you may be required to reschedule your appointment. Chronic non-payment will be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 45 days.

Patient Financial Responsibility: I acknowledge full financial responsibility for services rendered by Healthy Living Dallas. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays and any prior balance I may owe is due at the time of service unless a payment agreement is on file. I hereby request that payment of insurance benefits be made on my behalf to Healthy Living Dallas for any medical services or supplies furnished to me by that organization.

Signature of Patient	Date
Printed Name	Date of Birth

Healthy Living Dallas

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO PRIMARY CARE PHYSICIAN

I _____(patient name) authorize Dr. Anil Pinto and Anil Pinto, MD PA and his to help me with my health transformation. I understand that my program may consist of a modified food plan and nutraceuticals, a regular exercise program, and instruction in behavior modification techniques. It has been explained to me that these supplements, nutraceuticals, and medical foods have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature without adverse effect.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I, _____ (patient name), understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

I, _____ (patient name), understand that this program is voluntary to improve my health using nutraceutical and medical foods. Any primary health concerns outside of the biotransformation are not related to this clinic. I will consult my primary care physician for these concerns and understand that I will be referred back to the primary care physician if these concerns are brought up during the Healthy Living visit. I also understand that the practice has no relationship with an ER should any reasons require my visit to the emergency room. I understand that Anil Pinto MD PA and are not my primary care physicians. If I have any medical emergencies I will contact my primary care physician and proceed to the appropriate ER if needed. The following are details of my primary care physician:

PRIMARY CARE PHYSICIAN NAME: _____
PRIMARY CARE MD PHONE: _____ FAX: _____

By signing this form I request and authorize Anil Pinto, MD Healthy Living Dallas to release healthcare information to the primary care physician listed above. This request applies to all healthcare info unless restricted below. This authorization will be in effect unless a written request to change authorization is provided by the patient.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

_____ I do not authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
_____ I do not authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form. I understand that if no primary care physician information is provided to Healthy Living Dallas it is my responsibility to provide this information to a healthcare organization or professional that can make this information available in case of a medical emergency.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date of Signature: _____

Healthy Living Dallas

PATIENT PORTAL CONSENT AND AUTHORIZATION

Dr. Anil Pinto, MD of Healthy Living Dallas has made a patient portal available for use exclusively to our established patients. This portal may currently or may in the future provide access for patients to see upcoming appointments, instructions, exercise and dietary recommendations, additional educational resources, or more. The patient portal is designated to enhance patient-physician communications and to help patients better understand their lifestyle recommendations. We strive to keep all information in your records correct and complete. If you identify any discrepancy on your record you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information for our clinic. Information provided by the patient on the portal may be used in treatment of health conditions.

Guidelines and Security:

Healthy Living Dallas offers secure viewing and communication as a service to our patients who wish to view parts of their records and communicate with our staff. Even though patient portal follows HIPAA standards and we believe the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Healthy Living Dallas has undergone IT implementation and security standards in compliance with industry recommendations.

All new and established patients have signed HIPAA agreement forms and have been given a copy of our HIPAA policy. If you do not recall having signed HIPAA agreement form or need to reacquaint with our HIPAA policy, a copy can be provided to you for your review. Online display or recommendations and online documentation can be a valuable communication tools but have certain risks. In order to manage these risks we need to impose conditions of participation. While we try and ensure that all communication through the portal is secure, keeping it secure depends on two additional factors: the information available must reach the correct email address, and only the correct individual must be able to get access to it. If you think someone has learned your password, you do not remember your password, or your email address has changed, you should promptly contact Healthy Living Dallas for information on changing portal settings including passwords. Patient is responsible for the security of their own password. Healthy Living Dallas will not have access to your password and initial temporary passwords will only be shared with yourself. This will not be shared with any other individual including individuals listed on release for private health information. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information including your email address.

The patient portal may provide the following services, now or in the future:

- Information regarding dietary, exercise, and lifestyle modifications.
- Access to list of recommended medical foods or nutraceuticals along with dosing instructions and times when pertinent.
- Communication of long-term goals and instructions between staff and the patient.
- Limited communication regarding on-going treatment.
- Ability to track exercise or dietary patterns to aid in the treatment of health goals.
- Ability to view or print particular past laboratory results.
- Features may be added or removed from the portal by the sole discretion of Healthy Living Dallas without prior notification to or consent from patients.

Protecting Your Private Health Information and Risks:

If you have reason to believe that breach of HIPAA exists with the patient portal and Healthy Living Dallas has not satisfactorily remedied the situation, you may file a complaint to the Texas Medical Board at:

Texas Medical Board
ATTN: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. BOX 2018, MC-263
Austin, Texas 78768-2018
(800) 201-9353
http://www.tmb.state.tx.us/

Patient Portal Policies and Limitations:

The patient portal is provided as a courtesy to our valued patients. We are focused on providing highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal. Also the following policies and limitations apply:

1. We DO NOT provide emergency services for users of our site. If you have an emergency or other urgent matter you should contact your primary care physician by telephone or proceed to the closest emergency room.
2. No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees a provider.
3. No request for re-fill prescription medication will be accepted through the portal.
4. After you agree to the policy and procedures and sign the consent form, we will attempt to send a "Welcome Message" email to you. This will provide a link to the portal login screen. Patients will receive a portal login if Dr. Pinto or other qualified staff of Healthy Living Dallas feels that it will be beneficial to your treatment plan. Not every patient will receive or will need a patient portal.
5. If you have questions regarding portal function or use please call or email our office. We will normally respond to non-urgent email inquiries and phone calls within 48 hours. If you have not received a response email from us within 3 working days, please call the office. 24-hour portal support is not available.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between the physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Healthy Living Dallas should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. It is my responsibility to notify Healthy Living Dallas if I feel that my secure password has been breached. I agree not to hold Healthy Living Dallas or any of its staff liable for network infractions beyond its control. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

I understand that dietary recommendation food lists may contain foods to which I have documented food allergies or sensitivities. Healthy Living Dallas does not recommend you to consume foods that you know cause allergic responses or foods that cause other negative reactions regardless of whether they appear in recommended food lists. As a courtesy Healthy Living Dallas may remove these foods from your individual portal food lists upon written request by the patient. Regardless of whether these foods appear in recommended food lists on the patient portal it is the responsibility of the patient to avoid these foods. **Healthy Living Dallas is not responsible for the patient consuming a food that causes an allergic response or negative reaction regardless of whether previous negative reactions were known or unknown to the patient or to Healthy Living Dallas at the time of consumption.**

The patient portal may also provide exercise recommendations and tracking tools. Healthy Living Dallas strongly recommends that you consult with your primary care physician before beginning any exercise program. **If you engage in an exercise program, you agree that you do so at your own risk, are voluntarily participating in these activities, and assume all risk of injury to yourself. If at any time you feel that your exercise recommendations from Healthy Living Dallas will be unsafe for your body or current fitness level discontinue activity and inform Healthy Living Dallas.** A new exercise recommendation can be made for you individualized to meet your current fitness and comfort levels.

Desired Portal Password (PLEASE PRINT CLEARLY): _____ (Case Sensitive)
Must contain one letter, one number, one special character

Print Name: _____ Date: _____

Patient Signature: _____

Email: _____