Angela Pifer, MSN
Certified Nutritionist

Email Correspondence Authorization

____
Patient Name Date of Birth

____
Address City, State Zip Code Phone

By signing this form, I authorize Angela Pifer, Certified Nutritionist and Nutrition Northwest Co and to communicate with me via: ☐ **E-Mail** ☐ **Skype**

** Complete the following only if email correspondence is being authorized:

____
Patient's Email

** Required for Long Distance Patients:

____
Patient's Skype ID

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize release of my medical care and treatment to the following health care providers and from the following health care providers to Angela Pifer via verbal, mail and/ or fax communication:

Health Care Provider ___________________________

Health Care Provider ___________________________

I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers as a result of the communications:
(*Check all that are approved*.)

☐ **My personal health information contained in emails and my email address;**
☐ **Laboratory Test results, Pathology reports; and other diagnostic test results.**

Please initial If I cancel my appointment with less than 48 hours' notice I agree to pay a $159 late cancellation fee, due immediately.

I have read and agree that e-mail messages from Angela Pifer, and Nutrition Northwest Co to me may include protected health information about me whenever necessary. I understand that, by federal law, Angela Pifer and Nutrition Northwest Co may not use or disclose my health information, except as outlined in this form, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above.

I hereby release Angela Pifer, Nutrition Northwest Co and its employees from any and all liability that may arise from the release of information as I have directed. I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it. Angela Pifer, Nutrition Northwest Co and its employees will not be liable for information lost or misdirected due to technical errors or failures.

_______________________________________ Date:_____________
Patient Signature

The following confidentiality statement is included in all e-mails between patients, physicians and nutritionist: The preceding message contains information that may be privileged and/or confidential. The information is intended for the use of the designated recipient only. If you have received this email in error, please be advised that any disclosure, copying, distribution or other use of the contents is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

GENERAL CONSENT FOR TREATMENT AND CONSENT TO USE AND DISCLOSE HEALTH AND MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Welcome to Nutrition Northwest, Co. This handout summarizes important information that you should know about our services and provides us with your written consent for treatment/care by our licensed certified nutritionist as well as your consent to our use and disclosure of your protected health information for treatment, payment for services, and health care operations. We ask you to read it carefully, ask any questions that you may have, and then sign, date and return the form to us.

I. Services Offered

Nutrition Northwest, Co. provides a variety of services related to the nutritional care, prevention and treatment of conditions that benefit from nutritional therapy. The certified nutritionist in consultation will determine if the care needed involves resources or competencies beyond the scope of our services, and will, with the administrative coordinator for Nutrition Northwest, Co. provide the appropriate referral, documentation, and follow-up.

II. Confidentiality

Your medical records on file at Nutrition Northwest, Co., are treated as confidential records and will only be released pursuant to your authorization or as otherwise permitted or required by law. You may ask the certified nutritionist or administrative coordinator at Nutrition Northwest, Co. for a printed copy of this notice.

III. Your Responsibilities

Patients are expected to honestly answer the Patient Intake Form and provide a full and accurate medical history to our certified nutritionist at the time of their consultation.

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CONSENT FOR TREATMENT/CARE

I have read the above material regarding rights and responsibilities of the patient as it relates to the services provided by Nutrition Northwest, Co. I understand its provisions, and agree to receive services under the above conditions and I consent to treatment/care, as determined to be necessary by the certified nutritionist at the afore mentioned offices.

CONSENT FOR USE AND RELEASE OF INFORMATION

I give permission to Nutrition Northwest, Co. and other staff to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary:

1. For my treatment – to any physician, or other health care providers or facilities which need the information for my continued care, only with written authorization by me.

2. For payment purposes – to determine whether I am eligible for insurance coverage and if this treatment/care is authorized for payment by my insurance. This information may also be used to process an insurance claim, for billing and for collection purposes.

Patient Name (please print) ______________________________

Date of Birth___________________________ **Age**________

____ ____/___/___
Signature of Patient **Date**

____ ____/___/___
Signature of Parent/Guardian if patient is considered a minor **Date**

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PATIENT PROFILE

Last Name: ________________________________ First Name: ________________________________

Nickname: ________________________________ Birth date: ____________________ Gender: ______

<u>A note to my patients</u>: Please complete this three page questionnaire as thoroughly as possible in order to aid me in your treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

What goals do you have for your visit? ____

____

Have you ever consulted a Nutritionist or a Counselor before? (If yes, please circle) Y N

PRESENT HEALTH CONCERNS

Please list health concerns in their order of significance.	Was this diagnose, if so, how?	Indicate past and/ or present treatment
1.		
2.		
3.		
4.		

Please list prescription medications that you are currently taking, with dosages:

1.________________________ 2.________________________ 3. ________________________

4.________________________ 5.________________________ 6. ________________________

List vitamins, minerals, herbs, homeopathic remedies that you are <u>currently taking</u>, with brand, name and dosage.

* please line up all supplements at home, 4-5 at a time, take a photo front and back and email to me:

Current Supplement/ Brand/ Dose	Why are you taking it?	Prescribed by whom?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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Food Allergies/ Sensitivities
Please list KNOWN food allergies/ sensitivities that you have (you eat 'x' and 'x – symptom' happens) and the symptom that you experience:

KNOWN Food Allergen	Symptom(s)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Do you carry an epi-pen? Y N

Medical History
Please list any severe or life-threatening allergies: ____________________

Explain: ____________________

What is your current body weight? ________ Height?_________ Do you have a weight goal in mind __________________

If yes, when is the last time you were at this weight and how long were you able to maintain this? ____________________

Has your weight changed due to illness, in the past year(s) (please explain): ____________________

____

Personal Habits
Please mark any of the following that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: ____________________

____

Do you exercise regularly? Yes No What type? ____________________

How long?____________________How often? ________________

What equipment do you have access to (home gym/ gym membership, etc?) ____________________

What exercise do you see yourself doing on a regular bases?____________________

Sleep Habits: How many hours a night do you sleep? _________ What time to bed? _________ Time you wake?__________

Times you wake during the night? ________Times you wake to urinate? ________Do you wake feeling well rested?________

Have your sleep patterns changed over the past year(s), if so, how? ____________________

____

Past History:
Hospitalizations: ____________________

Date of last antibiotic round? ____________________ Is there a history of taking antibiotics? ____________________

How often do you take antibiotics and why? ____________________

____

Serious Illnesses and Injuries:____________________

____

Date of last physical/annual exam ________________________ Date of last blood tests: ____________________

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Symptoms:
Please mark all that relate to you.

Irritable bowel syndrome	gas, belching, fatigue after meals	Cough (unproductive)	Mood swings	Tinnitus (with normal hearing and other causes ruled out)
Skin rashes	Spastic Colon	Mental Dullness	Hoarseness	Sinus or migraine headaches
Vertigo	Post nasal drip	Muscle spasms, soreness/weakness	Asthma or asthma bronchitis	Chronic fatigue
Itchy eyelids	Fluctuating sensorineural hearing loss (feels like ears are stopped up)	Forgetfulness	Chronic fatigue syndrome	Weight fluctuations/ intermittent swelling or edema
Sleep apnea or insomnia	Cardiac rhythm disturbances	Depression aggravated or worsened by food allergies	Bloating	Intermittent diarrhea, and constipation

Social History:

Please mark those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) ___________________________

If you have a partner or roommate, are they supportive with your efforts to make changes to your health? Y N

If no, please explain____

What barriers do you foresee to meeting your health goals? ____

____

If you adopt these new changes and meet your health goals, what constructive changes will this bring to your life?

____

____

____