SIBO Guru

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 28 Day Health Solutions Co. (Angela Pifer's online health sites) and Nutrition Northwest Co. (Angela Pifer's private practice) and to communicate with me via: ☐ **E-Mail** ☐ **Zoom Video**

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

_____

Patient's Email

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.

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I have read and agree that e-mail messages from Angela Pifer, 28 Day Health Solutions Co, and Nutrition Northwest Co to me may include protected health information about me whenever necessary. I understand that, by federal law, Angela Pifer, 28 Day Health Solutions Co, 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, 28 Day Health Solutions Co, 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, 28 Day Health Solutions Co, 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.

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

Welcome to 28 Day Health Solutions Co. (Angela Pifer's online health sites) and Nutrition Northwest Co. (Angela Pifer's private practice). 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

28 Day Health Solutions Co and 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 28 Day Health Solutions Co and Nutrition Northwest Co provide the appropriate referral, documentation, and follow-up.

II. Confidentiality

Your medical records on file at 28 Day Health Solutions Co and 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 28 Day Health Solutions Co and 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 28 Day Health Solutions Co and 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 28 Day Health Solutions Co and 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: _____

A note to my patients: 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 currently taking, 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?
_____
_____
_____