2201 West Broad Street, Suite 107
Richmond, VA 23220
T/F (804) 977-2634
www.richmondnaturalmed.com

Nutrition and Herbal New Patient Intake

Name:____ Date: ______________________

Address: ____

City: ________________________________ State: ___________________ Zip Code: ________________

Phone (home):_________________________ cell: ___________________ other: ___________________

E-mail address: ____ Age: ___________________________

Date of Birth: ____

Live: ❑ Alone ❑ w/Partner ❑ w/Parents ❑ w/Children ❑ Other family ❑ Friends

Occupation: ❑ Work ❑ Unemployed ❑ Disabled ❑ Retired ❑ Volunteer ❑ Student

Current Occupation: ___________________________________ # of Hours Work/Volunteer_______________

If retired, disabled or unemployed, list last occupation: ____

Next of kin or emergency contact: ____

Relationship: _______________________________________ Phone: ________________________________

Address: ____

How did you hear about our clinic? ____

Are you under the current care of physician? ❑ Yes ❑ No If so, with whom: _________________________

If not receiving healthcare, when did you last receive health care? _____________________________________

What is/was the reason? ____

Do you currently have any contagious diseases? ❑ Yes ❑ No Please list: _____________________

Do you have any allergies? ❑ Yes ❑ No Please list: ____

What are your most important health concerns and what treatments have been used?

1. ____________________________________treatments used _______________________________________

2. ____________________________________treatments used _______________________________________

3. ____________________________________treatments used _______________________________________

What service(s) are you here for today? ____

I give the professionals at RNM permission to assist in my care. I understand that such professionals may include RNM employees, members, and independent contractors. I agree to indemnify and hold harmless RNM, its officers, members, independent contractors, directors, and employees from any and all damages and/or liability arising out of or related to services rendered. I also understand that if I do not give a 24-hour notice for an appointment cancellation or if I do not show for the appointment, I will be charged an insufficient notice fee.

____ ________ / __________ / __________

SIGNATURE DATE

Thank you for taking the time to complete this questionnaire.

Nutrition & Herbal Intake Form

Lindsay Kluge, M.Sc, CNS, LDN

Instructions for your first nutrition & herbal consultation:

Thank you for giving thoughtful consideration as you complete the enclosed New Client Questionnaire. You will have ample opportunity to address any concerns that require more detail during your appointment.

Required for your first visit:
- The completed New Client Questionnaire
- Signed Consent to Services form
- Signed HIPPA form

Please also bring the following:
- Any labs, blood tests or other pertinent medical information you think may be helpful.
- If you are taking any pharmaceuticals, over-the-counter drugs, herbs, and/or supplements, please bring them in their original containers so your practitioner can be sure to see what ingredients and amounts are in the products.

Client confidentiality will be observed under all circumstances.

If you have any questions please contact Lindsay Kluge at patients@richmondnaturalmed.com

New Client Questionnaire

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed
with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian.

Please allow 30-45 minutes to complete this questionnaire. Please answer the questions below as thoroughly as possible so that I may make the best possible clinical assessment and develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc, are important as they provide helpful context for establishing a productive partnership with you. That said, please answer only the questions you are comfortable answering.

Today's Date:

Basic Information:	
NAME:	
Medical Information	
WHAT HEALTH CONCERNS DID YOU EXPERIENCE AS A CHILD?	
WHAT HEALTH CONCERNS HAVE YOU EXPERIENCED AS AN ADULT?	
ARE YOU PART OF A RECOVERY PROGRAM?	IF SO, WHICH ONE?
DO YOU HAVE ANY ALLERGIES TO FOODS, MEDICATIONS, CHEMICALS, AND/OR OTHER ENVIRONMENTAL SUBSTANCES?	IF SO, WHICH ONE(S)?
WHAT IS YOUR TYPICAL REACTION AND HOW SEVERE IS IT?	
WHAT, IF ANY, SURGERIES/OPERATIONS HAVE YOU UNDERGONE, AND WHEN?	
HAVE YOU EVER BEEN HOSPITALIZED FOR REASONS OTHER THAN SURGERIES/OPERATIONS?	
IF SO, WHEN AND FOR WHAT REASONS?	
HAVE YOU HAD A MAJOR CHEMICAL EXPOSURE?	IF SO, WHEN? AND TO WHAT?
WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE OF THE U.S. OR CANADA?	
IS THERE ANYTHING THAT SURFACED DURING A RECENT MEDICAL TEST, LAB WORK, OR DOCTOR'S VISIT THAT YOU WOULD LIKE TO REPORT?	

Place an “X” next to anything you are currently experiencing. Issues that you had previously, but no longer have, mark with a “P”							
Skin/Musculoskeletal		**Circulatory**		**Nervous**		**Reproductive**	
	RASH		BRUISE EASILY		SEIZURES		SEXUALLY TRANSMITTED DISEASE
	ACNE		VARICOSE VEINS		HEADACHE		WOMEN: BREAST ISSUES
	CHANGING MOLES		SWOLLEN/PAINFUL LYMPH NODES		MIGRAINES		WOMEN: VAGINAL DISCHARGE
	SLOW WOUND HEALING	**Urinary**			INSOMNIA		WOMEN: YEAST INFECTIONS
	ARTHRITIS		BLADDER INFECTION		DEPRESSION		WOMEN: ABMORNAL PAP SMEAR
	GOUT		KIDNEY INFECTION		ANXIETY		MEN: BPH
Respiratory			KIDNEY STONES	**Endocrine**			MEN: ERECTILE INSUFFICIENCY
	DIFFICULTY BREATHING	**Gastrointestinal**			LOW BLOOD SUGAR	**Other/Cross Functional**	
Cardiovascular			BLOATING		HIGH BLOOD SUGAR/DIABETES		EYE PROBLEMS
	HIGH BLOOD PRESSURE		DIARRHEA				HEARING LOSS
	LOW BLOOD PRESSURE		CONSTIPATION				RINGING IN THE EARS
	HEART PALPITATIONS		GAS/FLATLULENCE				HAIR LOSS
	RAPID HEARTBEAT		HEMORRHOIDS				
	HIGH CHOLESTEROL		NAUSEA				
	STROKE		LIVER/GALL BLADDER ISSUES				

For Women: Pregnancies (please include losses/terminations):			
Year	**Vaginal/C Section**	**Sex**	**Complications/Other Things You Want to Mention**
ARE YOU CURRENTLY PREGNANT?			ARE YOU ACTIVELY TRYING TO CONCEIVE?
IT IS IMPORTANT THAT YOU INFORM YOUR PRACTITIONER IF YOU DECIDE TO CONCEIVE OR IF YOU BECOME PREGNANT.			

Family History		
Relationship	**Alive/Deceased**	**Present Health or Cause of Death**

Thank you for taking the time to complete this questionnaire.

PATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER		
MATERNAL GRANDFATHER		
FATHER		
MOTHER		
BROTHERS		
SISTERS		
CHILDREN/AGES		

Medications – Over-the-Counter and Prescriptions				
Name	**Dosage**	**Frequency**	**Length of Time**	**Reason for Taking**
ARE YOU SENSITIVE TO LOW LEVELS OF MEDICATION(S) AND/OR CAFFEINE?				

Vitamins, Minerals or Herbal Supplements				
Name/Brand	**Dosage**	**Frequency**	**Length of Time**	**Reason for Taking**

Thank you for taking the time to complete this questionnaire.

Nutrition + Lifestyle

Diet – Place a "check" in the appropriate column					
Food/Drink	**Never or Rarely** (less than once a month)	**Occasionally** (less than once a week)	**Regularly** (more than once a week)	**Most Days of the Week**	**Comments**
CAFFEINE					IN WHAT FORM?
SODA/SOFT DRINKS					WHAT TYPES?
ALCOHOL					WHAT TYPES?
RED MEAT					BEEF LAMB
WHITE MEAT					POULTRY PORK
EGGS					
FISH					
NUTS & SEEDS					
FRUITS					CANNED FRESH FROZEN
VEGETABLES					CANNED FRESH FROZEN
PLANT OILS (e.g. OLIVE)					WHAT TYPES?
DAIRY PRODUCTS					MILK YOGURT CHEESE BUTTER
SOY PRODUCTS					
BREAD/GRAINS					WHAT TYPES?
"JUNK/FAST FOOD"					WHAT TYPES?
FRIED FOODS					WHAT TYPES?

HOW MANY TIMES A WEEK DO YOU COOK EACH MEAL AT HOME?	BREAKFAST:	LUNCH:	DINNER:
HOW MANY OUNCES OF WATER DO YOU DRINK PER DAY?	BOTTLED: oz.	FILTERED: oz.	TAP: oz.
DO YOU HAVE ANY KNOWN FOOD ALLERGIES OR SENSITIVITIES? (LIST)	YES NO		
ON A SCALE OF 1-10, HOW WOULD YOU RATE YOUR DIET? (POOR) 1 2 3 4 5 6 7 8 9 10 (EXCELLENT)			

Thank you for taking the time to complete this questionnaire.

HOW WOULD YOU DESCRIBE MOST OF YOUR MEALS? (CIRCLE ALL THAT APPLY)	RELAXED WITH FAMILY SEATED AT TABLE	RUSHED IN FRONT OF COMPUTER IN THE CAR	STANDING UP ALONE IN FRONT OF TV
DO YOU CONSIDER YOURSELF:	UNDERWEIGHT	OVERWEIGHT	JUST RIGHT
DO YOU DIET FREQUENTLY?	YES	NO	
DO YOU SMOKE?	YES	NO	
WHAT ARE YOUR NUTRITION GOALS IN ORDER OF PRIORITY TO YOU? 1. 2. 3.			
WHERE DO YOU TYPICALLY DO YOUR GROCERY SHOPPING?			
DO YOU EAT FAST FOODS? IF YES, FROM WHERE?			
DO YOU HAVE GOOD ENERGY LEVELS?	YES	NO	

Activity – Place a "check" in the appropriate column					
Activity	**Never or Rarely** (less than once a month)	**Occasionally** (less than once a week)	**Regularly** (more than once a week)	**Most Days of the Week**	**Comments**
EXERCISE					WHAT TYPES?
SEXUAL ACTIVITY					
SOCIALIZING w/FRIENDS					
RELAXATION					WHAT TYPES?
RECREATIONAL DRUGS					WHAT TYPES?

Sleep
AT WHAT TIME ARE YOU TYPICALLY IN BED?
WHAT TIME DO YOU FALL ASLEEP?
TYPICAL HOURS ASLEEP?
NUMBER OF TIMES YOU WAKE DURING THE NIGHT?

Thank you for taking the time to complete this questionnaire.

REASON(S) WHY YOU WAKE DURING THE NIGHT?
DO YOU WAKE TO AN ALARM CLOCK?
DO YOU FEEL RESTED UPON RISING?

Stress

ON A SCALE OF 1-10, WITH 1 BEING LOW AND 10 BEING HIGH, HOW STRESSFUL IS YOUR:	WORK?	SOCIAL/FAMILY SITUATION?	CURRENT HEALTH STATUS?	LIFE IN GENERAL?

DO YOU FEEL THAT YOUR CURRENT STATE OF HEALTH IS: LARGELY IN YOUR CONTROL / LARGELY OUT OF YOUR CONTROL	WHAT DO YOU BELIEVE YOU CAN DO TO MAKE A DIFFERENCE IN YOUR CURRENT HEALTH STATUS?

Moods You Experience Frequently

	ACCEPTING		ANXIOUS / NERVOUS		ANGRY		CAPABLE		COMPASSIONATE
	DETERMINED		DREADFUL		EMPOWERED		ENTHUSIASTIC		FORTUNATE
	GUILTY		HAPPY		HOPEFUL		HURT		INSPIRED
	LONELY		LOVED		PEACEFUL		RESENTFUL		RESIGNED
	SAD		SCARED		TERRIFIED		TIRED		UNCERTAIN
	OTHER:		OTHER:						

Significant Life Events

Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, illness, and anything else you feel greatly impacted your life.

Date	Event

Thank you for taking the time to complete this questionnaire.

Constitutional Assessment - The following section provides us with an overview of your personal constitution, which is helpful information for determining which herbs and nutritional guidance are most appropriate for you. For this reason, please evaluate yourself as accurately and honestly as you can, based on how you have reacted in general throughout your lifetime, not how you react at present. Avoid the temptation to see yourself as you would like to be rather than as you are. There is no right or wrong, and no better or worse, in this assessment. There is only the reality of your personal constitution. Your answers may primarily appear in one column or they may cross multiple columns.

	Body Frame and Weight				
	NARROW SHOULDERS AND HIPS		MEDIUM SHOULDERS AND HIPS		BROAD SHOULDERS AND HIPS
	LOSE WEIGHT w/out DIFFICULTY GAIN WEIGHT w/ DIFFICULTY		LOSE OR GAIN WEIGHT w/out DIFFICULTY		LOSE WEIGHT w/ DIFFICULTY GAIN WEITHE w/out DIFFICULTY
	Skin and Nails				
	SKIN IS COLD TO THE TOUCH ESPECIALLY HANDS AND FEET		SKIN IS WARM TO THE TOUCH		SKIN IS CO0L TO THE TOUCH
	SKIN IS DRY, OR OILY AND DRY		SKIN IS OILY		SKIN IS MOIST AND SUPPLE
	SWEAT IS SCANTY, EVEN IN HEAT		SWEAT IS PROFUSE, EVEN IN COLD		SWEAT IS MODERATE, CONSISTENT
	NAILS ARE HARD AND BRITTLE		NAILS ARE SOFT AND STRONG		NAILS ARE THICK AND STRONG
	Appetite				
	VARIABLE APPETITE		STRONG APPETITE		MODERATE APPETITE
	VARIABLE INTEREST IN FOOD		ENJOY EATING		MODERATE INTEREST IN FOOD; AT TIMES PRONE TO EMOTIONAL EATING
	DIZZY OR FAINT w/out SNACKS		IRRITABLE IF MEALS ARE MISSED		CAN MISS MEALS w/out ANY PHYSICAL DISTRESS
	Digestion and Evacuation				
	DEFECATE ONE/FEW TIMES PER WEEK		DEFECATE MULTIPLE TIMES PER WEEK		DEFECATE ONCE DAILY
	STOOLS OFTEN HARD; DARK COLORED		STOOLS SOFT TO LOOSE; YELLOWISH		STOOLS WELL FORMED; RARELY HARD; MEDIUM-BROWN COLORED
	STOOLS MOVE WITH STRAIN		STOOLS MOVE EASILY		STOOLS MOVE WITH STRAIN
	RESPOND TO LAXATIVES		NO NEED FOR LAXATIVES		RESPOND TO LAXATIVES
	Menstruation				
	IRREGULAR CYCLES		REGULAR, LONG LENGTH CYCLES		REGULAR, AVERAGE LENGTH CYCLES
	SCANTY FLOW, SOMETIMES CLOTTING		HEAVY FLOW		MODERATE FLOW
	BLOOD IS DARK IN COLOR		BLOOD IS BRIGHT RED		BLOOD IS LIGHT IN COLOR
	CONSTIPATION BEFORE PERIOD		LOOSE STOOLS BEFORE PERIOD		PRONE TO WATER RETENTION
	SHARP, INTENSE CRAMPS		MEDIUM INTENSITY CRAMPS		DULL, ACHY CRAMPS
	Physical Strength and Endurance				

	ENERGY COMES IN SPURTS/BURSTS; PREFER TO EXPEND IT WHEN AVAILABLE		CONSTANT SUPPLY OF ENERGY; DRIVE TO BE ACTIVE CAN CAUSE OVERLOAD		PREFER NOT TO EXPEND ENERGY, BUT FEEL GOOD WITH REGULAY ACTIVITY
	LIKE VIGOROUS EXERCISE, BUT IT EVENTUALLY EXHAUSTS		LIKE VIGOROUS EXERCISE AND CAN ENDURE IF PACED WELL		ENDURE VIGOROUS EXERCISE WELL, BUT PREFER NOT TO PARTAKE
Sleep					
	DIFFICULT TO FALL ASLEEP		EASY TO FALL ASLEEP UNLESS WORRIED		EASY AND QUICK TO FALL ASLEEP
	LIGHT OR VARIABLE SLEEPER; DIFFICULT TO RETURN TO SLEEP WHEN WAKENED		LIGHT SLEEPER; RETURNS TO SLEEP EASILY WHEN WAKENED		SLEEP SOUNDLY THROUGHOUT THE NIGHT; RARELY WAKENED
	RARELY ACHIEVE ADEQUATE SLEEP		GET BY ON MINIMAL SLEEP		PREFER MANY HOURS OF SLEEP
	RISE FEELING UNRESTED		RISE FEELING ALERT		RISE FEELING RESTED AND ALERT
Voice					
	TALKATIVE; SPEAK QUICKLY		CONCISE AND DIRECT IN SPEAKING		TALK WHEN THERE'S SOMETHING TO SAY
	TENDENCY TO STRAY FROM SUBJECT		SPEAKING IS PURPOSEFUL		SPEAKING IS SLOW AND CAUTIOUS
Personality Traits					
	SENSITIVE		STRONG AND FORCEFUL		CALM AND QUIET
	HIGH STRUNG/ANXIOUS		DOMINEERING/OPIONATED		PATIENT/COMPASSIONATE
	RARELY SEE PROJECT THROUGH		SEE PROJECTS THROUGH		SEE PROJECTS THROUGH STUBBORNLY
	FRIENDSHIPS ARE OFTEN SHORT-TERM		FRIENDSHIPS SERVE A PURPOSE		FRIENDSHIPS ARE OFTEN LONG-TERM
Memory					
	REMEMBER AND FORGET EASILY		REMEMBER EASILY AND FORGET w/DIFFICULTY		MUST BE TOLD MORE THAN ONCE TO REMEMBER, BUT THEN IT STICKS
Lifestyle					
	DIFFICULT TO FORM HABITS		MAKE OR BREAK HABITS EASILY		ENJOY HABITS

APPOINTMENT & CANCELLATION POLICY

New patient visits are 1 hour and 30 minutes in duration and return visits are 60 minutes. If you are unable to make your scheduled appointment ***you are required to provide at least 24 hours notice***. This allows us to meet the needs of other patients that need an appointment and may be on a waiting list. Due to this, follow-up appointments that are cancelled without providing a 24-hour notice will be charged a $75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a $100 insufficient notice fee. We charge your credit card on file if you do not call and cancel your appointment within the timeframe outlined above. Notification allows the practitioners to see other clients who need to be cared for that day.

Thank you for taking the time to complete this questionnaire.

PAYMENT POLICY

Richmond Natural Medicine strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and products.

PAYMENTS: We accept cash, Visa, MasterCard, Discover and American Express. We also accept payment by check and debit cards. We hold a credit card number on file to secure your appointment and to secure necessary fees for breach of our cancellation policy. Richmond Natural Medicine will send clients accounts to collections for balances not paid after two failed attempts to collect on balances past due by 60 days or more. Payment plans are offered at management's discretion. We reserve the right to require payment for services to be made at or before the time of service.

OUTSTANDING BALANCES: We may refuse to see patients who have large balances or are not making regular payments on their balance. If you have an unpaid balance at the end of a billing cycle, we may apply a $5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principle. In the event hat your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance. In the event of an "insufficient fund" check, there will be a $25 insufficient funds charge added to the balance due.

CANCELLATIONS: *We charge your credit card on file if you do not call and cancel your appointment within the timeframe outlined above.* Notification allows the practitioners to see other clients who need to be cared for that day.

NEW CLIENT & FOLLOW-UP APPOINTMENTS*: Follow-up appointments that are cancelled without providing a 24-hour notice will be charged a $75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a $100 insufficient notice fee. Failure to show for an appointment will also result in a charge to your credit card.*

DEPENDENTS: You are responsible for payment of services rendered to your dependents on your account.

I authorize Richmond Natural Medicine to keep my signature on file and to charge my credit card (held in our secure system) for:

1. Charges associated with appointments that are not cancelled within the timeframes listed above.
2. Charges associated with payment arrangements. Contact management to make payment arrangements.

Attestation Statement:

I have read, understand, and agree to the above Richmond Natural Medicine Payment Policy. I understand that charges are my responsibility. I acknowledge that these policies do not obligate Richmond Natural Medicine to extend credit.

____

Print name of Patient

____________________________________ ____________________

Signature of Patient Date

Thank you for taking the time to complete this questionnaire.

Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. Copies are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you come to Richmond Natural Medicine for a treatment or consultation. Your symptoms, the practitioner's assessment, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of Richmond Natural Medicine, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibility: Richmond Natural Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Richmond Natural Medicine reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice,
Richmond Natural Medicine agrees not to use or disclose your health information without your consent.

Contact information:
Richmond Natural Medicine
2201 W Broad St. Suite 107
Richmond, VA 23220

Practices Regarding Disclosure of Client Health Information

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment/Consultation: Information obtained by your practitioner at Richmond Natural Medicine will be entered in our record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectation and those of others involved in your care may also be recorded.
Payment: Your record will be used to receive payment for services rendered by Richmond Natural Medicine. A bill may be sent to either you or received directly upon services rendered.

Quality Monitoring: Richmond Natural Medicine will use your health information to assess the care you received and compare the outcome of your care to others. Your information maybe reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services provided.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA): This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Public Health: This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.

Law Enforcement: As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member of business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is Richmond Natural Medicine's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Richmond Natural Medicine will request your authorization whenever disclosure of personal health
information is necessary to parties other than those referenced here:

Business Associates: Some or all or your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Communications with Family: Using best judgment, a family member, close personal friend identified by you personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Consent

I consent to the use or disclosure of my protected health information by RNM for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of RNM. I understand that analysis, diagnosis, or treatment of me by RNM may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RNM is not required to agree to the restrictions that I may request. However, if RNM agrees to a restriction that I request, the restriction is binding on RNM.

I have the right to revoke this consent, in writing, at any time, to the extent that RNM has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of RNM and understand that I have a right that Notice's of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RNM. The Notice of Privacy Practices for RNM is also available at the front desk at 2201 W Broad St. Suite 107, Richmond, VA. This notice of privacy practices describes my rights and duties of RNM with respect to my protected health information.

RNM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by calling the office of RNM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Individual or Guardian Date

____

Print Name

Thank you for taking the time to complete this questionnaire.

HIPPA Privacy Authorization Form

This form is required by the Health Insurance Potability and Accountability Act (HIPPA), Section 45 C.F.R. Parts 160 and 164 Authorization.

I, _____________________________, authorize Richmond Natural Medicine (RNM) to use and disclose the protected health and demographic information to the individuals working within the establishment. Also, this authorization will expire one year from today's date: ___/___/___

You have the following rights:

- I have a right to refuse to sign this authorization.
- I have a right to receive a notice about my privacy policies.
- I have a right to request and access my medical information.
- I have a right to limit the uses and disclosures of my medical information.
- This medical information will only be used by the person I authorize to receive this information health care and health consultation or other purpose I may authorize.
- I understand that I have a right to withdraw this authorization, in writing, at any time during my care. I acknowledge that a withdrawal is not effective to the extent that any person or entity has already acted in reliance on my authorization.

__ I do not give anyone (family, caregiver, friends) access to my medical information related to my care.
__ I do give the following individuals access to my medical information related to my care:

Name(s) ____

Expiration of access ________________________

____
Signature of patient of personal representative

____
Printed name of patient of personal representative

____
Date

Thank you for taking the time to complete this questionnaire.