



East West Nutrition

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by **East West Nutrition** and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
-

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us directly at:
 - **East West Nutrition**
 - **rcamerongardner@gmail.com**
 - **[Phone number]**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling , calling 1-877-696-6775.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice is effective as of the date that this document is signed.

Client Signature

In signing this document, I acknowledge that I have received and agree to terms outlined in the HIPAA Notice of Privacy Practices.

X

Print Name:

Date:



East West Nutrition

Assumption of Risk and Release of Liability

I hereby acknowledge and agree:

1. The purpose of nutritional counselling is to improve the overall health, vitality and well-being of the body through nutritional education and the use of natural foods and non-medicinal nutritional supplements. The **Clinical Nutritionist/Strength Coach, Cameron Gardner**, does not diagnose diseases, disorders or conditions.
2. The **Clinical Nutritionist/Strength Coach, Cameron Gardner**, is not a licensed Dietitian, Naturopathic Doctor or Medical Physician.
3. As part of the Nutritional Counselling Services, I may be asked to provide information concerning my physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet. This information is collected to enable the **Clinical Nutritionist/Strength Coach** to: (i) assess my knowledge of nutrition, (ii) educate me about the benefits of sound nutritional practices and (iii) recommend dietary changes to improve my general health, vitality and overall well-being. The **Clinical Nutritionist/Strength Coach, Cameron Gardner** will hold this information in confidence and will not release or disclose this information to any other person, without my prior consent, except as required by applicable law.
4. If the **Clinical Nutritionist/Strength Coach, Cameron Gardner**, suspects the existence of disease, disorder or condition, I will be informed of this suspicion. However, I acknowledge this is not a diagnosis or conclusion about the state of my health and that I am directed to promptly consult a licensed Physician or Naturopath about any suspected problems.
5. Should I request the **Clinical Nutritionist/Strength Coach, Cameron Gardner**, to recommend dietary changes and/or nutritional supplements to enhance my body's natural ability to resist and/or overcome a known disease, disorder or condition, it is my responsibility to disclose the nature of the disease, disorder or condition and all other relevant details to the **Clinical Nutritionist/Strength Coach, Cameron Gardner**. If I have not previously consulted a licensed Physician or Naturopath about this disease, disorder or condition, I acknowledge that I am directed to promptly do so. I am not to alter or discontinue treatments prescribed by a licensed Naturopath, Physician or other licensed health professional without consulting the individual who prescribed the treatment.
6. In providing Nutrition Counselling Services to me, the **Clinical Nutritionist/Strength Coach, Cameron Gardner**, is relying upon the truth, accuracy and completeness of all information I have

provided to her. Any recommendations I follow for changes in diet, including the use of nutritional supplements, are entirely my responsibility.

7. **Cameron Gardner** is in no way liable for my health or safety.

8. In consideration of my participation in the **Nutritional Counselling Services**, I hereby accept all risk to my health, including injury or death that may result from such participation and I hereby release the **Clinical Nutritionist/Strength Coach, Cameron Gardner**, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin, and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, including my death, that may result from or occur as a result of my participation in the **Nutrition Counselling Services**, whether caused by negligence or otherwise.

9. **24 hours** is required for cancelling appointments. Appointments cancelled within **24 hours** of your appointment time, you will be billed a **\$50 fee**.

10. I understand that any therapies I undertake at **East West Nutrition** are undertaken of my own free will. I accept that the ultimate responsibility for my health care is my own and that **East West Nutrition** is here to support me in this. I understand that my practitioner reserves the right to determine which cases fall outside their scope of practice, in which event an appropriate referral will be recommended. I hereby agree to assume full responsibility for any manner of loss, injury, claim or damage whatsoever, known or unknown, incurred as a result of same and I, my heirs, executors, administrators or assigns for any loss, injury, claim or damage sustained as a result of my attendance and/or participation. I have read the above release and waiver of liability, and fully understand its contents and voluntarily agree to the terms and conditions stated.

Client Signature

I HAVE CAREFULLY READ THIS AGREEMENT AND AGREE TO THE TERMS OUTLINED ABOVE. I UNDERSTAND THIS AGREEMENT TO BE A FULL AND FINAL RELEASE OF ALL COSTS, CLAIMS, CAUSES OF ACTION AND DAMAGES OF ANY KIND ARISING FROM OR IN CONNECTION WITH THE **NUTRITION COUNSELLING SERVICES**.

X

Print Name:

Date:



East West Nutrition

Intake Questionnaire

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Occupation

Hours per week

Referred by

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics?

☐ Yes ☐ No

If so, when?

Have you ever taken birth control?

☐

Yes

☐

No

If so, when?

Have you ever been on hormone replacement therapy?

☐

Yes

☐

No

If so, when?

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement?

☐ Yes ☐ No

Are your bowels loose?

☐ Yes ☐ No

Do you take laxatives?

☐ Yes ☐ No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods?

☐ Yes ☐ No

Diet

How much water do you drink daily?

Do you consume coffee?

☐ Yes ☐ No

If so, how much, how often?

Do you consume tea?

☐ Yes ☐ No

If so, how much, how often?

Do you consume alcohol?

☐

Yes

☐

No

If so, how much, how often?

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food

Please be very specific

Height

Weight

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep?

Do you wake frequently during the night?

Do you wake feeling rested?

☐

Yes

☐

No

How often do you exercise?

What types of exercise do you do?

What level of stress are you currently experiencing?

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

Chemicals

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

What is your level of commitment to improving your health?

☐

1

☐

2

☐

3

☐

4

☐

5

☐

6

☐

7

☐

8

☐

9

☐

10

1 = Lowest, 10 = Highest

Provide a detailed description of your daily routine- time you wake up and go to bed, everything you drink and eat, everything you do (workout, work, School). If weekdays are different please clarify.

Training:

Do you have any injuries which prevent you from doing certain exercises and if so what's the injury?

Which exercises are affected by the injury or which exercises are you unable to perform?

Do you have any specific strength goals (i.e. squat 315 x1) or body parts you'd like to focus on? If so Please list below.

Do you have any home cardio equipment?

