

*Sophia Grace Center*

**New Patient Information**

\*Phone: (281) 313-2298

[www.sophiagracecenter.com](http://www.sophiagracecenter.com)

Name:		Date:
Referred by:		
Street Address:		
City, State, Zip Code:		
Home Phone:		Work/Cell Phone #:
Email Address:		
Birth Date:	Age:	Sex:
Marital Status:		

Physician Name:		Phone #:
Blood Pressure:		Cholesterol Level:
Triglycerides:		Blood Type:

Type of Work:		
Place of Business:		
Number of Children:	Age(s):	Sex:
Number of Children Living at Home:		
Spouse Name:		Age:

How would you rate your current state of health?
What is your reason for seeing a dietitian?

<i>Personal Medical History (please check all that apply):</i>	
<input type="checkbox"/> Heart Disease or Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Cancer <input type="checkbox"/> Lung Problems <input type="checkbox"/> Food Allergies <input type="checkbox"/> Ulcer <input type="checkbox"/> Gastrointestinal Disorder <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other:	<input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Arthritis <input type="checkbox"/> Anemia <input type="checkbox"/> Chewing Problems <input type="checkbox"/> Food Sensitivities <input type="checkbox"/> Gallbladder Disorder <input type="checkbox"/> Constipation <input type="checkbox"/> Other Allergies
Family Medical History:	

*If you take any of the following, please list names and dosage:*

Vitamins and/or mineral supplements:

Herbal supplements:

Prescription medication:

Over-the-counter medications:

What are your exercise habits? Please include type of activity, how often, and length of each session.

*In your household:*

Who does the grocery shopping?

Who does the cooking?

How often do you eat out?

When you eat out, where/what type of restaurant do you go to?

*For females:*

Age at onset of menstrual cycle:

Age at onset of menopause:

Do you experience severe cramping/PMS/mood swings before or during your menstrual cycle?

*Please recall and list the foods you have consumed within the last 24 hours (or for a typical day):*

<u>Breakfast</u>	<u>Snacks</u>	<u>Lunch</u>	<u>Snacks</u>	<u>Dinner</u>	<u>Snacks</u>

PLEASE DO NOT WRITE BELOW THIS LINE

Current Weight:

Usual Weight:

Weight Change:

Height:

Build/Frame:

Notes:

SOPHIA GRACE CENTER FOR NUTRITION, HEALTH, AND SPIRITUALITY, LLC
<b>PAYMENT POLICIES</b>

**Cancellation Policy**

Welcome to Sophia Grace Center! I am pleased to have the opportunity to assist you in your nutritional needs and look forward to helping you reach your goals. Due to the nature of my business, I have a 24-hour cancellation policy. Cancellations made 24 hours in advance of a scheduled appointment will not be charged. Cancellations made within 24 hours of a scheduled appointment, as well as failure to be present at any appointment without prior notification, **will be charged at full price**. Please understand that this policy enables me to better serve my clients.

**Payment Policy**

Payment is due at the time of service unless other arrangements have been made with me.

Please feel free to contact me with questions or concerns regarding these policies. I am also always available for additional questions outside of an appointment regarding your nutritional needs. I look forward to serving you!

Client Signature: _____ Date: _____
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<b>SOPHIA GRACE CENTER FOR NUTRITION, HEALTH, AND SPIRITUALITY, LLC</b> <b>RELEASE OF HEALTHCARE INFORMATION</b>
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I authorize the release of information contained in my/my child's medical record to Laura Laine RD LD. Specifically, I authorize any hospital, nursing home, physician's office, home health agency or any other health facility where I have been/my child has been a patient, to disclose any part or all of my/my child's medical record to Laura Laine RD LD. Also, I authorize the release of medical information by Laura Laine RD LD to other health care facilities and healthcare providers whose services may be required in conjunction with the services provided by Laura Laine RD LD

I understand that this medical information may include, where applicable, psychiatric, alcohol, drug abuse and specific laboratory results of HIV infection or the diagnosis of AIDS. I understand this consent is subject to my revocation at any time, except to the extent that disclosures have already been made in reliance on my consent.

Signature of Parent/ Guardian/Patient: _____	Date: _____
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Signature of Witness: _____	Date: _____
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Relationship to Patient: _____	Date: _____
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<b>SOPHIA GRACE CENTER FOR NUTRITION, HEALTH, AND SPIRITUALITY, LLC</b> <b>NOTICE OF PRIVACY PRACTICES</b>
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*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with Sophia Grace Center (SGC). Specifically, “protected health information” is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

SGC is required to follow specific rules on maintaining the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your rights to access and control your protected health information. It also describes how SGC follows applicable rules and use and discloses your protected health information to provide your treatment, obtain payment for services you receive, manage SGC’s health care operations and for other purposes that are permitted or required by law. If you have any questions about this notice, please contact SGC.

#### Your Rights under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with SGC.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** – SGC is required to follow the terms of this notice. SGC reserves the right to change the terms of notice, at any time if needed. New versions of this notice will be effective for all protected health information maintained at that time. Upon your request, SGC will provide you with a revised Notice of Privacy Practices if you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

**You have the right to authorize other use and disclosure** – This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or SGC has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to designate a personal representative** – This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

**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 that is contained in your patient record. There will be a fee for copying and obtaining a copy of medical records.

**You have the right to request a restriction of your protected health information** – This means you may ask SGC, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to 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. In certain cases, SGC may deny your request for a restriction.

**You have the right to request an amendment to your protected health information** – This means you may request an amendment of your protected health information for as long as this information is maintained by SGC. In certain cases, SGC may deny your request for an amendment.

**You have the right to request disclosure accountability** – This means that you may request a listing of disclosures that SGC has made, of your protected health information, to entities or persons outside of SGC other than for the purposes of treatment, payment, healthcare operations, or a purpose authorized by you.

## How SGC May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that SGC is permitted to make.

**Treatment** – SGC may 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 a third party that is involved in your care and treatment. SGC will disclose protected health information to other healthcare providers who may be involved in your care and treatment. SGC may also call you by name in the waiting room when your healthcare provider is ready to see you. SGC may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. SGC may contact you by phone or other means to provide information that describes or recommends treatment alternatives regarding your care. Also, SGC may contact you to provide information about health related benefits and services offered by my office.

**Payment** – Your protected health information will be used, as needed, to obtain payment for you health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services SGC recommends 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.

**Healthcare Operations** – SGC may use or disclose, as needed, your protected health information in order to support the business activities of this practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

**Others Permitted and Required Uses and Disclosures** – SGC may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

**To Others Involved In Your Healthcare** – Unless you object, SGC 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, SGC may disclose such information as necessary if SGC determines that it is in your best interest based on professional judgment. SGC 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, general condition or death. 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. In this case, only the protected health information that is relevant to your health care will be disclosed.

**As Required By Law** – SGC may use or disclose your protected health information to the extent that the use or disclosure is required by law.

**For Public Health** – SGC 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.

**For Communicable Diseases** – SGC 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.

**For Health Oversight** – SGC may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

**In Cases of Abuse or Neglect** – SGC may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, SGC may disclose your protected health information if it is believed that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.

**To The Food and Drug Administration** – products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

**For Legal Proceedings** – SGC 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), in certain conditions in response to a subpoena, discovery request or other lawful process.

**To Law Enforcement** – SGC may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.

**To Coroners, Funeral Directors, and Organ Donation** – SGC may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. SGC may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**In Cases of Criminal Activity** – Consistent with applicable federal and state laws, SGC may disclose your protected health information, if it is believed that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. SGC may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**For Military Activity and National Security** – When the appropriate conditions apply, SGC may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service.

**For Workers' Compensation** – Your protected health information may be disclosed by SGC, as authorized, to comply with workers' compensation laws and other similar legally established programs.

**When an Inmate** – SGC may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosure** – Under the law, SGC must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

#### Complaints

You may address complaints to SGC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated, a complaint can be filed by notifying SGC.

I, \_\_\_\_\_, have read and understand the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_