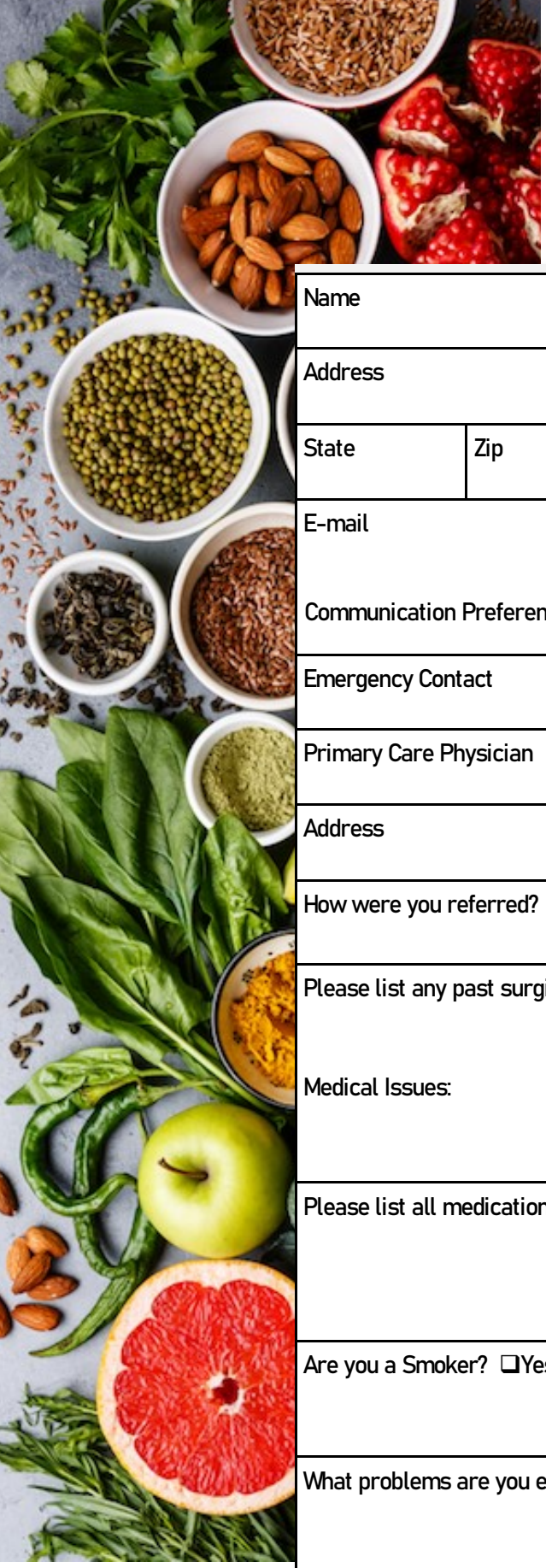
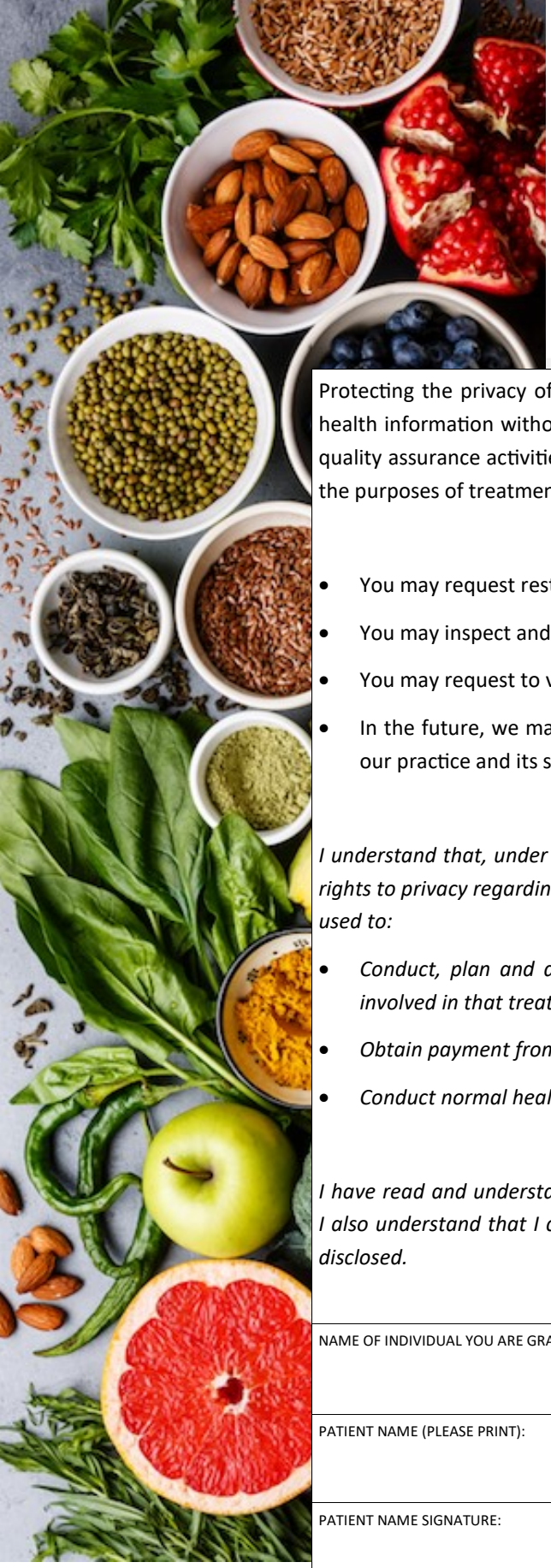


Nourish
Custom Nutrition

Nutrition Intake Form

Name			Birth date
Address			City
State	Zip	Home #	Cell #
E-mail Communication Preference Phone Email			Marital Status Spouse Name
Emergency Contact			Phone #
Primary Care Physician			Phone #
Address			
How were you referred?			
Please list any past surgical procedures: Medical Issues:			
Please list all medications and all supplements you are currently taking:			
Are you a Smoker? ❑Yes ❑No		How many alcoholic drinks do you consume per day ____ per week ___	
What problems are you experiencing that bring you to this appointment?			
When did your symptoms begin?			
Are they getting worse?			



Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

NAME OF INDIVIDUAL YOU ARE GRANTING PERMISSION	RELATIONSHIP TO PATIENT AND PHONE NUMBER
PATIENT NAME (PLEASE PRINT):	
PATIENT NAME SIGNATURE:	DATE:

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Goshorn Wellness Center 725 Ridge Road Webster, NY 14580 585-671-0934