Total Health Guidance

Nutrition

Welcome!

We are honored to have the opportunity to work with you. This packet contains information and forms that we will need to have on file for the first meeting.

Please review and complete the following documents:

1. Referral Sources – for you to review.
2. Client Information Form - to be completed and returned to counselor.
3. Disclosure Statements - to be reviewed, *signed,* and returned to counselor.
4. Disclaimer of Liability - to be reviewed, *signed,* and returned to counselor.
5. HIPAA Notice of Privacy Rights – keep for your records.

TOTAL HEALTH GUIDANCE
www.TotalHealthGuidance.com

REGIONS BANK BUILDING
5401 S. KIRKMAN RD. #760
ORLANDO, FL 32819

(321)-332-6984

REFERRAL SOURCES

We network with a group of trusted professionals on a weekly basis. If you are looking for someone to help you with any of the following services, please place an X next to that category and I will provide you with their business card or contact information.

Our counselor will review this page and answer any questions you may have.

Client Name: _____ Date: _____ Okay to share: E-mail: Y / N - Phone: Y / N

____ Attorney – Criminal Defense
____ Attorney - Family (Divorce, Custody, Child-support, etc.)
____ Attorney – Business Law
____ Photographer
____ Digital Marketing (SEO, Website Design, Video, Social Media)
____ Financial Planner (Investments, IRA, 401k, etc.)
____ Counselor/Life Coach (Individual, Marriage & Family, Career)
____ Residential Real Estate (Buying or selling)
____ Business Internet / Phone / Cable TV
____ Banker (personal or business)
____ A/C & Heating (sales & service)
____ Business Consulting
____ Nutritional Counselor
____ Acupuncture
____ Massage Therapy
____ Health Insurance (Individual & Group benefits)
____ Life Insurance
____ Residential Mortgage (purchase, re-fi, construction, reverse)
____ Marketing / Advertising
____ Insurance (Auto, Home, Business)
____ Wedding Minister
____ Pest Control (Home or Business)
____ CPA (Audit representation, Tax returns, Business Start-ups)
____ Handyman/ Lawn Maintenance
____ Merchant Services
____ Payroll Services
____ Printing/ Promotional Products
____ Interior Design
____ Caterer
____ Legal Shield/ Identity Theft
____ Medical Doctor / Primary Care Physician
____ Private Investigator

Total Health Guidance

New Client Information

Name_____ **Date**_____

Address_____

City_____ **State**_____ **Zip**_____

Cell # _____ **Work #** _____ **Home #** _____

E-Mail_____ **Occupation**_____

Age_____ **Weight**_____ **Height**_____ **Referred By**_____

What is your main complaint or area of interest?

_____

Family History (check all that apply):

Stroke_____
High BP_____
Depression_____
Heart Disease_____
Arthritis (RA or OA) _____
Cancer___, Type? _____
Diabetes_____
Weight Problems_____
Ulcer_____
Psoriasis_____
Glaucoma_____
Thyroid Problems_____

Personal History (check all that apply):

- ☐ Arthritis
  - RA _____
  - OA _____
- ☐ Stroke
- ☐ High Cholesterol
  - How High? _____
- ☐ High Blood Pressure
  - How High? _____
- ☐ Diabetes
  - Type 1 _____
  - Type 2 _____
- ☐ Low Blood Sugar
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Multiple Chemical Sensitivities
- ☐ Infectious Mononucleosis
- ☐ Frequent Colds/Flu
- ☐ Herpes/ HPV
- ☐ Cold Sores
- ☐ Cancer
  - What type? _____
  - Chemo? _____
  - Rads? _____
  - Steroids? _____
- ☐ Surgeries
  - What type? _____
- ☐ Thyroid Problems
  - Hypo _____
  - Hyper _____
- ☐ Headaches
  - Chronic Tension _____
  - Migraines _____
  - Cluster _____
  - Hormonal _____
- ☐ Food Allergies
  - To What? _____
- ☐ Seasonal Allergies
  - To What? _____
- ☐ Medication Allergies
  - To What? _____
- ☐ Sleep Problems
- ☐ Forgetfulness
- ☐ Hot Flashes
- ☐ PMS
- ☐ Birth Control Pills/ Hormones
- ☐ Weight Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Cramping/ Bloating
- ☐ Yeast Infections
- ☐ Low Libido
- ☐ Ulcers

What Medications and Dosages are you taking? List all please:

_____

_____

What Vitamins and herbal supplements are you taking? List all please:

_____

_____

Do you eat, drink, or use (circle all that apply):

Antacids	Tobacco	Candy	Aspirin	Alcohol	White Bread	Tylenol
Coffee	Ibuprofen	Soda	Laxatives	Diet Soda	Fried Foods	Tea
Butter	Margarine	Protein Drinks	Fast Foods	Chewing Gum	Appetite Suppressants	

Artificial Sweeteners: Blue, Pink, Yellow

List any food aversions and/or foods you dislike:

_____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

_____

Do you crave any of these certain foods? (Circle all that apply)

Sweets Chocolate Bread/Pasta Fried Foods Alcoholic drinks Sodas/Diet Sodas Meat

Other: _____

Are you:

Under excessive amounts of stress _____ at home_____ at work_____ other location_____

Physical Stress_____ Mental / Emotional Stress_____

Exposed to second hand smoke regularly_____

How often do you have bowel movements? _____ times per day/ week/ month

Urinate? _____ times per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums? Etc.

_____

Are your nails week or brittle? _____ **Average Hrs. of sleep per night?** _____

Any sleeping problems? _____

On a scale of 1 – 10 with 10 being great, how would you rate your current health in each of these areas?

Financially ____ Spiritually ____ Nutritionally____ Emotionally____ Relationally____

To what extent are you currently willing you commit to achieving better health?

Little_____ Moderate _____ Major_____ Extreme_____

Is there anything else about either your history or your current condition that you feel is important to mention?

_____

_____

Total Health Guidance, LLC. – Disclosure Statement

Thank you for deciding to seek out treatment at Total Health Guidance. We have listed below our various policies for your information. Please read through these, ask any questions, and sign at the bottom. You may call (321) 332-6984 regarding any questions you may have. All of the therapists at THG are licensed through the State of Florida and/or the Florida Association of Christian Counselors & Therapists. Total Health Guidance is not a 24 hour treatment center. In an emergency, please call 911.

SESSIONS
Initial sessions are typically scheduled for 1.5 hours. Follow up sessions will be determined by the coach and client.

PAYMENT POLICY
We see clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session. Our policy is for each person receiving counseling, testing, or coaching services to pay for such service at the time they are rendered. Any other arrangements must be made in advance. A $25 administrative fee will be charged on all checks that are returned for non-sufficient funds. Payments can be made by cash, check, or credit card. Charges for testing services are an additional fee.

INSURANCE
If you desire to use in-network benefits, confirmation of coverage must be completed prior to your appointment. We are not in-network with many insurance carriers. Until coverage is confirmed, you will be required to pay in-full for all appointments. If you desire to use out-of-network benefits, please direct questions about reimbursement amounts and timeliness to your insurance company. We can provide you with a receipt for the counseling service that may be used to submit for reimbursements if you choose. We do not complete any insurance paperwork for out-of-network benefits. If you elect to use your health insurance plan to assist in the payment of treatment then you understand that your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for processing.

CANCELLATIONS
We understand that it may, at times, be necessary to cancel an appointment. We require that **changes / cancellations be made 24 hours in advance**. **Any changes, cancellations, or missed appointments within the 24 hour period will result in a $40 cancellation charge.**

CONFIDENTIALITY
The confidentiality of the services provided by us is protected by law. Unless you grant us permission to do so in writing, we will neither inform anyone that you are a client, nor will we disclose the content of any session. The only circumstances under such professional confidentiality may be broken is if one or more of the following conditions apply:

If you pose a serious physical danger to yourself or to another person.
If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person.
If you disclose that a child, an incompetent or a disabled person is suffering because of neglect.

If such abuse or neglect is disclosed, we are mandated by Florida law to report such information to an appropriate state agency.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
I have read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees. I have received a copy of our HIPAA Notice of Privacy Rights.

_____
Signature of Client or Legal Guardian

_____
Date

Total Health Guidance

Disclaimer of Liability

The staff of Total Health Guidance (THG) are not medical doctors and the scope of their consultation services does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a medical doctor without delay. Only a medical doctor can prescribe drugs. Any mention of drugs in the course of consultation is only for the purpose of providing a complete history of drugs that the client is taking and not for THG staff to judge the appropriateness of the medication. Any change in prescription or dosage is a decision the client makes with his or her physician.

Rather than dealing with treatment of disease, THG focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. As counselors, acupuncture physicians, and health/nutrition coaches, THG primarily educates and motivates clients to assume more personal responsibility for their health by adopting a healthy attitude, lifestyle, and diet.

While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, THG does not promise or guarantee protection from future illness.

By signing below, you acknowledge that you understand that the staff of THG are not medical doctors, and that you should see a doctor if you think you have a medical condition. THG will not be held liable for failure to diagnose or treat an illness, nor will they be liable for failure to prevent future illness.

Additionally, you promise to give THG a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

Client's Signature _____ Date_____

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Notice of Privacy Practices

Please keep for your records

This Notice describes the confidentiality of your medical information, and the limited ways that medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that protected information. We are required to abide by the terms of this Notice of Privacy Practices, and to provide you with notice of our legal duties and privacy practices with respect to protected health information you provide to us. If you have any questions about this Notice, please contact the privacy officer, John Stiteler, at this office.

Who Will Follow This Notice

Your counselor and all business associates working with Total Health Guidance (THG) who share your personal health information, such as insurance or managed care companies, must follow these same privacy practices. When personal health information is shared, only the minimum necessary information needed to accomplish this task will be disclosed.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

In most cases, THG may not use or disclose information in your health records that could identify you (Protected Health Information) without your written authorization except for the reasons described below. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

How We May Use and Disclose Medical Information Without Your Authorization

There are limited circumstances where an authorization is not needed for disclosure of personal information. Most, but not every possible use or disclosure category are listed below. This Notice applies primarily to information contained in your medical and billing records. More detailed and personal information contained in provider's "psychotherapy notes" are kept separately, and are given an even greater degree of privacy and protection than the personal health information contained in your medical and billing records. As such, these would require written authorization even for the standard disclosure exceptions listed below.

For Payment. We may use and disclose medical information about you without specific authorization so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may release your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment. In most cases, insurance companies may review your medical record to verify services were rendered and were medically necessary in accordance with your contract.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization. We may, at our discretion, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you without your specific release.

- To avert a serious threat to health or safety
- Child abuse or neglect
- Abuse of elderly or incapacitated adults
- Court ordered evaluations or information
- Health oversight activities, such as for federal enforcement of these privacy practices

Your Rights Regarding Complaints Concerning Use or Disclosure of Your Health Information. If you believe your privacy rights have been violated, you may file a complaint with THG's Privacy Officer or with the Secretary of the Department of Health and Human Services, whose address will be provided to you by the Privacy Officer, at your request. All complaints must be submitted in writing.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, THG is not required to automatically agree to a restriction you request if the provider is otherwise obligated to release that information. Your request must be in writing and specifically state what information you wish to limit.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of private health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a provider at this practice. Upon your request, this practice will send your bills to another address, or arrange to call you only at work instead of home.)

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of private health information in this practice's mental health and billing records used to make decisions about you for as long as the information is maintained in the records. On your request, your provider or the privacy officer will discuss with you the details of the request process.

Right to Amend. You have the right to request an amendment of private health information as it is maintained in the record. Your provider may deny your request if, in his or her opinion, it would compromise the accuracy of your medical information.

Right to an Accounting. You generally have the right to receive an accounting of any disclosures of medical information. On your request, your provider or the privacy officer will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of this notice from your provider or the practice upon request, even if you have agreed to receive the notice electronically.

Changes To This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.