Jeri Evans Nutrition, Inc.

Intuitive Release Therapy Questionnaire

PLEASE PRINT USING BLACK OR BLUE INK ONLY

Name: _____ Sex: M F Birth date: ___/____/____

Address: _____City:_____Zip:_____

Phones ***(please list a "good" number:)*** **_____/_____/_____ _____/_____/_____ Email:_____**

Occupation _____ Emergency Notification _____

Height _____ Weight _____ Drivers Lic # _____ Exp Date ___/____/____

Physician or Healthcare Provider Name:_____ Ph: _____

Please circle all that apply. Feel free to discuss with your therapist, if you have any questions.

Have you been drinking 64oz of water? **Y N**	*If No,*	How much do you drink?	
Are you sleeping 8 hours? **Y N**	*If No,*	What time do you wake up?	How Often?
Can you lie down? **Y N**	*If No,*	Can you sit for the session? **Y N**	
Are you meditating? **Y N**	*If Yes,*	How often?	

Please check all that apply.

☐ **depressed**	☐ **head traumas**	☐ **regular headaches**	☐ **feel desperate**
☐ **anxious**	☐ **want change**	☐ **feel stuck**	☐ **want emotional growth**
☐ **want spiritual growth**	☐ **obsessive**	☐ **get sick often**	☐ **obstacles keep reoccurring**
☐ **are you dreaming**	☐ **sensitive**	☐ **have premonitions**	☐ **boundary issues**
☐ **lack of feeling**	☐ **fearful**	☐ **angry**	☐ **are you usually happy**

If you are currently being treated for a specific condition (s) please list: _____

List all medications and supplements that you take regularly (including over-the-counter):

_____

_____

Have you ever had major surgery (include dates): _____

Number of bowel movements (on average) per day? _____ Do you need to strain? Y N Somewhat

What would you like to receive from this session? _____

How did you learn of our services? _____

Signature of client: **Signature of Guardian if applicable:**

_____ Date: _____ _____ Date: _____

Rev. 3/7/2010

JERI EVANS NUTRITION, INC.

HEALTH CARE PRIVACY

Notice of Privacy Practices

Protecting Your Confidential Health Information is Important to us. This notice describes how health information about you may be disclosed and how you can get access to this information. Please review it carefully.

The Federal HIPPA (Health Insurance Portability and Accountability Act) laws were written to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance for the privacy of health information is the rapid evolution of computer technology and its use is healthcare. The government has appropriately sought to standardize and protect the privacy of electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it.

Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable Client. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information. Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by Clients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business, and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities. Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our Clients to be sure they receive the best preventative and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders). We will notify government authorities if we believe a Client is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when

we believe we are specifically required or authorized by law or with the Client's agreement. We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device. As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime. We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participation in providing your care. We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral. Advancing medical knowledge often involves learning from the careful study of the medical histories of prior Clients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Client Acknowledgment of Notice of Privacy Practices and Authorization to use or disclose health information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Client Name _____

Client Signature _____ **Date** _____

YOUR RIGHTS

Restrictions - You have the right to request on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our Clients.

Confidential Communications - You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor reasonable requests for confidential communication.

Inspect and Copy Your Health Information - **You have the right** to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information - **You have the right** to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information - You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your requests to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice - You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our Clients receive a copy of this notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy has been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Jeri Evans Nutrition, Inc.

The Business and Professions Code of the State of California

The following is Pursuant to State of California Senate Bill 577 Section 2053.6

*** All clients must read, understand and sign this disclosure ***

I The Nutrition Services and Intuitive Release Therapy provided by Jeri Evans Nutrition, Inc. do comply with Section 2053.6 and 2053.5 of the Business and Professions Code of the State of California. In compliance with this code, one must be advised:

A There are NO licensed physicians in the office connected with Jeri Evans Nutrition, Inc. and the individuals performing Nutrition Consultation and/or Intuitive Release Therapy are not physicians.

This means and implies that he/she cannot and will not:

- Conduct surgery or any other procedure on another person that punctures the skin or harmfully invades the body.
- Administer or prescribe X-Ray or radiation to another person.
- Prescribe or administer legal drugs or controlled substances to another person.
- Recommend the discontinuance of legal drugs or controlled substance prescribed by an appropriately licensed practitioner.
- Willfully diagnose & treat physical or mental condition of any person under circumstance or condition that cause or create a risk of great bodily harm, serious physical /mental illness, or death.
- Set fractures or Treat lacerations or abrasions through electrotherapy.
- Hold out, state, indicate, advertise to a client or prospective client that he/she is a physician/surgeon.

B Nutrition Consultation and Intuitive Release Therapy are alternative or complimentary to the healing arts services.

C The therapist that provides the service of Nutrition Consultation and Intuitive Release Therapy is not licensed by State of California

D All services provided by Jeri Evans Nutrition, Inc. have never been in any clinical or medical trials or studies to prove the therapies either beneficial or harmful.

II Jeri Evans's Education:

- Bachelor of Science Degree in Foods and Nutrition
- Practitioner of Past Life Therapy
- Certificate from the Institute of PSI Biotics

III Services:

A Nutrition & Weight Management may include the following:

- Review of past and current food plans
- Discussion of nutritional deficiencies
- Reviewing client signs, symptoms, metabolism from the health histories, forms and current status

- Discussion of laboratory tests
- Discussion of diet plans
- Discuss and review supplement list
- Weight, height and body measurements

B Intuitive Release Therapy:

The client and Jeri Evans discuss personal goals. They and relax into a meditative state by breathing and utilizing visualization techniques. Jeri Evans is an Empath, Medium and Clairvoyant. All three modalities maybe incorporated into the session.

C Spiritual Counseling:

Jeri Evans is an Empath, Medium and Clairvoyant. All three modalities may be incorporated into the session to contact answer questions or contact those that have passed on.

I acknowledge that I have read the above disclosure and have been given a copy of this document. The information was provided to me in a language I can read and understand. Any questions should be asked at the time of the first visit. For further explanation of services, I will read the pamphlets provided or access Jeri Evans Nutrition, Inc. website, www.jerievansnutrition.com.

Client Signature _____ Date _____/_____/_____

I understand that as a condition of any agreement to provide services to me, I agree to waive any and all claims, causes of action and lawsuits that I may have, believe that I have, now or at any future date against Jeri Evans or Jeri Evans Nutrition, Inc. for services already provided or to be provided in the future, for any amount in excess of the fee that I have paid for such services.

Client Name (Print) _____

Client Signature _____ Date _____/_____/_____