OKLAHOMA NUTRITION THERAPY, PLLC
3351 W Rock Creek Rd, Ste 120 Norman, OK 73072
Phone: 405-801-2840

Consultation Agreement

This agreement is established for you to understand the nature of our relationship, the qualifications and services offered by Oklahoma Nutrition Therapy, PLLC and your rights and responsibilities as a patient.

Oklahoma Nutrition Therapy, PLLC, only employs licensed and registered dietitians that meet the State of Oklahoma standards for registered dietitians.

1. Qualifications:

Lisa C. Gibson, MS, RD/LD

- Dietetic Internship, University of Oklahoma Health Sciences Center
- Master of Science, Nutrition Science, University of Oklahoma Health Sciences Center
- Bachelor of Science, Food & Nutrition, University of North Alabama

2. Services:

Oklahoma Nutrition Therapy, PLLC, provides a wide range of nutrition services, including, but not limited to, disordered eating, eating disorders, weight loss/management, sports nutrition, prenatal nutrition, and medical nutrition therapy.

3. Confidentiality:

Oklahoma Nutrition Therapy, PLLC, adheres to the standards of HIPAA for all interactions with a patient. (Please see additional HIPAA form).

4. Fees & Cancellation Policy:

Oklahoma Nutrition Therapy, PLLC, schedules patients by appointment only and requires payment at the time of service. Fees are based on type of services provided and time spent with patient (see Fee Schedule). **Patients will be charged $50.00 for cancellation (without 24 hours notice) or not attending a scheduled appointment**. Payment types accepted include cash, credit card, & check (a fee of $35 will be applied to account for returned checks). Insurance may be accepted, prior authorization may be required (please inquire about insurance when scheduling).

"I, THE UNDERSIGNED, AM RESPONSIBLE FOR PAYMENT OF CARE AND AGREE TO PAY FOR THE SERVICES I RECEIVE AT THE TIME OF SERVICE."

PRINTED NAME: _____

SIGNATURE_____ **DATE:**_____

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-Hippocrates

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Medical / Nutrition History

TODAY'S DATE:_____

CLIENT'S NAME:_____

PARENT'S NAME (if minor):_____

DOB:_____ **SEX:**_____ **AGE:** _____

HOME ADDRESS: _____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

HOME PHONE: _____ **CELL:** _____ **WORK:** _____

EMAIL:_____

PLACE OF EMPLOYMENT: _____ **JOB TITLE:** _____

MARITAL STATUS: M S D W Number of persons in household: Adults _____ **Children**_____

PRIMARY PHYSICIAN: _____ **DATE OF LAST VISIT:**_____

EMERGENCY CONTACT INFORMATION:

(1) NAME: _____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PHONE: _____ **RELATION:**_____

(2) NAME: _____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PHONE: _____ **RELATION:**_____

How did you hear about Oklahoma Nutrition Therapy? _____
May I contact them to thank them for the referral? _____
Please briefly describe what you hope to obtain from our consultation? _____

_____

_____

_____

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Personal Health History (Check all that apply)

Heart condition		**Diabetes (insulin dependent)**	
Heart attack		**Diabetes (non Insulin dependent)**	
Heart catherization		**Thyroid disease**	
Heart Surgery		**Lack of energy**	
Angina		**Slow wound healing**	
High blood pressure		**Brittle nails**	
Abnormal Heart Beat		**Skin Rash**	
Enlarged veins in legs		**Tingling in hands or feet**	
Swelling in hands/feet		**Broken bones**	
Leg Cramps		**Arthritis/rheumatism**	
Asthma		**Paralysis**	
Tuberculosis		**Stroke**	
Swelling of joints		**Depression**	
Sleep Apnea		**Bipolar**	
Reflux		**Inpatient psycho therapy/counseling**	
Stomach Ulcers		**Outpatient psychotherapy/counseling**	
Gallbladder disease		**Poor growth**	
Hepatitis		**Anemia**	
Jaundice		**Dyspigmentation of skin**	
Crohn's		**Easily Bruise**	
Ulcerative Colitis		**Dark Concentrated Urine**	
Liver Disease		**Changes in Taste**	
Fainting Spells		**Glossy Red Tongue**	
Dizziness		**Dry cracked lips**	
Nose Bleeds		**Dry scaly skin**	
Blurred Vision		**Dry brittle hair**	
Spots in line of sight		**Hair loss (recent)**	
Changes in vision		**Thin sparse hair**	
Recurrent sores in mouth		**Dry eyes**	
Gum soreness or bleeding		**White spots on fingernails**	
Food Avoidance		**Sudden unexplained weight loss or gain?**	
Binge Eating		**Weight loss surgery**	
Anorexia		**OTHER** _____	
Bulimia		**OTHER** _____	

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Medical & Lifestyle Questionnaire

Alcohol intake: # drinks per day _____ per week_____ per month _____Type of Alcohol_____

Tobacco usage: never smoke currently smoke quit smoking _____ ago Chew tobacco: Yes or No

Drug usage (marijuana etc….) NO _____ YES _____ (Please describe type & how often)

_____

CURRENT MEDICATIONS (Please list all medications-use the back if you need more space)

Medication ***Amount*** ***Purpose***

_____

_____

_____

CURRENT HEALTH CONDITIONS (Please indicate any medical diagnoses that you are currently being treated for & provide the name of the provider that manages the condition.)

Condition/Disease ***Treatment Provider***

_____

_____

_____

CURRENT SUPPLEMENT USE (Please list all vitamins, herbal remedies, diet aids, etc… you are currently taking)

Supplement Name ***Amount*** ***Purpose***

_____

_____

_____

Weight History

Estimated Height: _____ Estimated Current Weight: _____Usual Weight: _____

Highest Adult Weight: _____at age _____Lowest Adult Weight: _____at age _____

Goal Weight: _____ Pounds gained this year: _____ Pounds lost this year: _____

Is anyone in your family overweight? Y N Is so, who? _____

Weight at age 5: _____Weight at age 13: _____ Weight at age 18: _____
Weight at age 21: _____Weight at age 30: _____Weight at age 40: _____
Weight at age 50: _____Weight at age 60: _____Weight at age 65: _____

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Please answer the questions below:

Do you currently want to lose weight? Y N
Have you ever taken diet pills? Y N
Have you ever been put on a special diet? Y N
If so, what type and when,_____

_____

Did you stay on this diet? Y N
List problems you had with the diet: _____

_____

Have you ever seen a registered dietitian before? Y N
If so, where and under what circumstances: _____

_____

Does anyone in the household follow a special diet? Y N
If so, what type of diet/foods: _____
Who cooks meals at your home? _____
Who does the grocery shopping? _____
What % of meals are eaten away from home? _____
What type of exercise do you do? _____
Describe your exercise routine: _____
How would you describe your eating habits? Good Fair Poor
Has your appetite changed recently? Y N
How many times a day do you eat? _____
How long does it take you to eat? _____
Do you difficulty eating, chewing, or swallowing? Y N
Do you ever go on an eating binge? Y N
Does this still occur? Y N
Have you ever induced vomiting after you eat? Y N
Do you ever feel extremely guilty after eating? Y N
Do you find yourself preoccupied with food? Y N
Do you avoid certain foods? Y N
If so, which foods: _____
Have you ever taken laxatives or diuretics for weight loss? Y N
Do you skip meals? Y N
Do you clean your plate even when you are full? Y N
Do you eat when preparing meals or storing leftovers? Y N
Do you eat standing up? Y N
Do you salt your foods at the table? Y N
Do you drink coffee or tea? Y N
How much? _____
Does your weight depress you? Y N
Do your emotions/feelings affect food choices? Y N

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Food Frequency Questionnaire

This questionnaire is designed to learn what foods you like or dislike.

Instructions: Please cross out any foods you would prefer not to eat or would not buy at the grocery store.

Dairy

Skim milk	1% milk	2% milk	Chocolate milk
Soy milk	Plain low-fat yogurt	Fruited low-fat yogurt	Cottage cheese
Swiss cheese	Cheddar cheese	Grated cheese	
Other:			

Protein

Beef	Chicken	Turkey	Fish
Pork	Ham	Bacon	Sausage
Eggs	Tuna fish	Peanut butter	Shrimp
Soy meat	Black beans	Pinto beans	
Other:			

Starch

Bagel	Pancakes	Corn	White or wild rice
English muffin	Waffles	Potatoes	Pasta
White or wheat bread	French toast	Peas	Popcorn
Pita bread	Granola	Sweet potato	Pretzels
Crackers	Squash	Flat bread	French fries
Dinner roll	Taco shells		
Cereal (hot and cold):			
Chips (potato, tortilla, etc):			
Other:			

Fruits

Apple	Blueberries	Peaches	Apple juice
Applesauce	Cantaloupe	Pears	Orange juice
Banana	Watermelon	Strawberries	Grape juice
Orange	Muskmelon	Mango	Mixed berry juice
Mandarin orange	Pineapple	Dried fruit	Cranberry juice
Grapes	Plum	Canned fruit	
Other:			

Vegetables

Asparagus	Cucumber	Mushroom	Iceberg lettuce
Cauliflower	Green beans	Sweet peppers	Romaine lettuce
Broccoli	Brussels sprouts	Mixed vegetables	Leaf lettuce
Celery	Onion	Roasted vegetables	Spinach
Carrots	Tomato	Oriental vegetables	
Other:			

Condiments and dressings

Butter	Creamy salad dressing	Salsa	Guacamole
Margarine	Italian salad dressing	Guacamole	Hummus
Cream cheese	Spaghetti sauce	Sour cream	
Other:			

Favorite restaurants/menu selection List your top three restaurant/menu selections:

1. _____

2. _____

3. _____

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Consent To Release Or Receive Confidential Information

I/We understand that records are protected under Federal and State Law and Regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

I/We do hereby authorize:(Name or Organization):_____

To release to: :(Name or Organization):_____

The following information/records regarding:
(Name of Client)_____,DOB ____/____/____ for records covering the time periods of:_____ through _____.

Specific information to be released:

_____

_____

Purpose and/or need for disclosure:

_____

_____

Method of Transmittal of Information: _____ mail, _____ fax, ____ e-mail, _____verbal, _____other (please list)

_____

Information is to be released (check all that apply):
___at the beginning of treatment ___during the course of treatment ___ at the completion of treatment ___as needed

The information authorized for release may include information which may indicate the presence of a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
Re: Psychiatric Records-Oklahoma State Law (76 O.D. Supp. 1986, Section 19) provides that psychological or psychiatric records may be provided to a patient if the treating physician or practitioner consents to the release or upon receipt of a court order, issued by a court of competent jurisdiction. Therefore psychological or psychiatric records will not be released to patients, their guardians or agents (including attorneys) except with the consent of the treating physician or practitioner or upon receipt of a court order, issued by a court of competent jurisdiction.
Re: Drug/Alcohol Abuse Records-Confidentiality of drug/alcohol abuse records is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

I/We understand that I/We have the right to revoke this authorization, in writing, at any time, by sending such written notification to Oklahoma Nutrition Therapy, PLLC. I/We understand that a revocation is not effective to the extent that Oklahoma Nutrition Therapy, PLLC has relied on the use or disclosure of the protected health information.

Oklahoma Nutrition Therapy, PLLC, will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits if applicable on whether I provide authorization for the requested use or disclosure.

I/We understand that I/We may revoke this consent at any time except to the extent that actions have been taken in reliance on it. This consent will expire on: _____

_____	_____	_____	_____
Client	Date	Parent or Guardian	Date
_____	_____	_____	_____
Staff/Witness	Date	Clinician's Review (If release is to client/family member)	Date

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Email Consent Form

Client Name: _____ Date: _____

Email Address: _____

RISK OF USING ELECTRONIC MAIL

Transmitting client information by email has a number of risks that clients should consider before using email. These include, but are not limited to, the following:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can easily misaddress an email.
- Backup copies of email may exist even after the sender of the recipient has deleted his or her copy.
- Employers and on-line services have the right to inspect email transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Emails may not be secure and therefore it is possible that a third party may breach the confidentiality of such communications.

CONDITIONS FOR THE USE OF ELECTRONIC MAIL

Oklahoma Nutrition Therapy, PLLC (ONT) cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. ONT and its employees are not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Patients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
- Email must be concise. The client should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- All email will be printed and filed in the client's medical record.
- Office staff may receive and read your messages.
- The client should not use email for communication regarding sensitive medical information.
- Provider is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's responsibility to follow up and/or schedule an appointment if warranted.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between Oklahoma Nutrition Therapy, PLLC and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with clients by email.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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