The GI & BARIATRIC NUTRITION CENTER, LLC.

Nancy Lum, RD, LDN

Welcome to The GI & Bariatric Nutrition Center (GIBNC). Nancy Lum, RD, LDN, President/ Owner, has been practicing since 2001 and has been involved in multiple medical disciplines with a concentration in GI and Bariatric Nutrition since 2002. She created the Bariatric Nutrition program at Sinai Hospital in Baltimore, MD in 2003 and has been published in The Bariatric times in 2010 and 2011. Nancy is currently seeing patients with multiple GI diagnoses, diabetic, cardiac, and general weight loss patients from various medical practitioner referrals and word of mouth. Nancy has developed and is currently running the Bariatric Nutrition program for the Director of the Bariatric Program at St. Agnes Hospital, Dr. Andrew Averbach, located at St Agnes Hospital in Baltimore, MD. We do not work for St. Agnes Hospital or their physicians. We are a private practice SCORP company that provides all pre-surgery and post-surgery educational services for the bariatric patients at St Agnes Hospital. We are not paid by the hospital or physicians for services. Nancy is also co-founder of STRIVE Motivational Group Therapy – est. 2012; which focuses on nutrition, lifestyle and behavior modification to get to the root cause of eating habits.

Our mission is to greatly improve the quality of our patients' lives by empowering patients through extensive cutting edge nutrition education and providing unique tools necessary for long term weight loss success and the reduction of medical co-morbid conditions. Our primary goal as nutrition experts is to build long term relationships with patients by educating, encouraging, supporting, and leading patients through the journey of permanent lifestyle change.

Our client expects to be treated with the utmost care and concern for their well-being and provided with a detailed and thorough education with access to long term follow up care. We look forward to assisting and advising you throughout the process of having surgical weight loss. The nutritional and lifestyle changes you will be making are of the utmost importance to your success with the procedure. We want to provide comprehensive nutrition education to ensure your success. We look forward to sharing our expertise and knowledge with you.

GIBNC does not participate with insurance companies, including Medicare. Payment is due, from the patient, in full, at the time of service. We reserve the right to refuse service if payment is not made at the time of service. Please see our attached "Financial Policy" for details on fees. Please read the paperwork attached prior to this appointment, and complete the attached questionnaire and forms. By signing you are agreeing to enter into a consultation agreement with The GI and Bariatric Nutrition Center and understand your financial responsibilities to GIBNC.

Sincerely,

Nancy Lum

Nancy Lum, RD, LDN, President/Owner

P: 443-490-1240
F: 443-490-5060
Websites & Social Media:
GIBNC www.Nutrition5.com; STRIVE MD Motivational Series: www.StriveMD.com
Facebook: https://www.Facebook.com/GIBNC
Twitter: https://Twitter.com/#!/GIBNC
Pinterest: https://Pinterest.com/GIBNC
YouTube: http://www.Youtube.com/user/GIBNC5

Nancy Lum, RD, LDN

Nutrition & Eating Habits Questionnaire:

It is REQUIRED that you bring the questionnaire **completed** to your appointment.

Please complete the below questionnaire and attached HIPAA authorization. If you are a surgical patient please also complete the attached finance policy, requirements to be cleared for surgery and supervised weight loss documentation sheets. Bring completed forms to your initial consultation as they are a required part of the documentation needed. Failure to bring completed can result in delay of your ability to be cleared for surgery as this to be sent out for data entry which can take 1-2 weeks.

There is a $5.00 fee for printing this questionnaire at appointment *if you fail to bring with you.*
Prior to your appointment you may also opt email on our contact form on www.nutrition5.com or fax to 443-490-5060.

CONTACT INFORMATION

Today's Date: _____/_____/_____

FIRST NAME, MIDDLE INITIAL	LAST NAME	DOB ____/____/____ MM DD YYYY	AGE

MARITAL STATUS: M S D W DP	Significant other authorized to come to classes (see pg. 9) with you:	**MEDICAL INSURANCE PROVIDER:** **Is this Medicare, Medicaid, or Medical Assistance?** ☐ YES ☐ NO

Referring Doctor (check on, or provide name):

Dr. Andrew Averbach ☐	**Dr. Kuldeep Singh** ☐	**Dr. Isam Hamdallah** ☐

OTHER:
_____

Do we have permission to release your information to your referring physician(s), when appropriate, in order to better coordinate your care? ☐ **YES** ☐ **NO** **If YES, Please complete the attached form on pages 12-13**

STREET ADDRESS (include unit number)	CITY, STATE	ZIP

HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL ADDRESS	Would you like to be added to our EMAIL support group list? ☐ YES ☐ NO

OCCUPATION	HOURS WORKED WEEKL _____HRS	DO YOU TRAVEL FOR WORK? ☐ YES ☐ NO How often? _____

Goals and Readiness Assessment:

I would like to meet with a dietitian, today because:

_____

_____

_____

My food and nutrition-related goals are:

_____

_____

_____

My overall, health goals are:

_____

_____

_____

If I could change 3 things about my health and nutritional habits, they would be:

1. _____
2. _____
3. _____

PHYSICAL INFORMATION

What is your current WEIGHT?	_____#
HEIGHT	_____' _____"
Have you had any recent changes in your weight that you are concerned about? If YES, please explain:	☐ YES ☐ NO
In the last 12 months have you (check one, then enter amount to right) ☐ **GAINED** ☐ **LOST**	_____#

MEDICAL HISTORY

COMORBIDITIES	☑	DIGESTIVE/ GI RELATED DISORDERS	☑	OTHER CONDITIONS	☑
CORONARY ARTERY DISEASE		BARRETTS ESOPHAGUS		ANEMIA/ IRON DEFICIENCY	
DIABETES TYPE I		CELIAC DISEASE		ANXIETY	
DIABETESE TYPE II		CHRONIC CONSTIPATION		BIPOLAR	
HIGH BLOOD PRESSURE (aka Hypertension or HTN)		CROHNS DISEASE		DEPRESSION	
HIGH CHOLESTEROL		DIVERTICULITIS		GRAVES DISEASE	
PRE-DIABETES		DIVERTICULOSIS		HASHIMOTOS DISEASE	
SLEEP APNEA		IRRITABLE BOWEL (IBS/ IBD)		HYPERTHYROIDISM	
HIGH TRIGLYCERIDES		REFLUX DISEASE (GERD)		HYPOTHYROIDISM	
		ULCERATIVE COLITIS		LACTOSE INTOLERANT	
				OCD	
				OSTEOPENIA	
				OSTEOPOROSIS	
				PCOS	
				PSORIATIC ARTHRITIS	
				RHEUMATOID ARTHRITIS	
				STROKE	
				VITAMIN D DEFICIENCY	

MEDICAL SYMPTOMS (Check ALL that apply)

HEAD	☑	EYES	☑	SKIN	☑
Headaches		Bags or Dark Circles		Acne	
Faintness		Blurred or tunnel vision (does not include near/far-sightedness		Hives, rashes, dry skin	
Dizziness				Hair loss	
Insomnia				Flushing, hot flashes	
				Excessive sweating	
HEART	☑	**DIGESTIVE TRACT**	☑	**JOINT/MUSCLE**	☑
Irregular or skipped heartbeat		Nausea, vomiting		Pain or aches in joints	
Rapid or pounding heartbeat		Diarrhea		Arthritis	
Chest pain		Constipation		Stiffness or limitation of movement	
		Bloated feeling		Pain or aches in muscles	
		Belching, passing gas		Feeling of weakness or tiredness	
		Heartburn			
		Intestinal/stomach pain			
WEIGHT	☑	**ENERGY/ACTIVITY**	☑	**MIND**	☑
Binge eating/drinking		Fatigue, sluggishness		Poor memory	
Craving certain foods		Apathy, lethargy		Confusion, poor comprehension	
Excessive weight		Hyperactivity		Poor physical coordination	
Compulsive eating		Restlessness		Difficulty in making decisions	
Water retention					
Underweight					
EMOTIONS	☑	**MENSTURATION**	☑	**OTHER**	☑
Mood swings		Menstrual cycle		Frequent illness	
Anxiety, fear, nervousness		Irregular cycles		Frequent or urgent urination	
Anger, irritability, aggressiveness					
Depression					

Are you currently pregnant? YES NO N/A
Do you plan to get pregnant within the next 12 months? YES NO NA

Do you SMOKE cigarettes? YES NO, If YES, how many cigarettes per day? _____

OTHER MEDICAL CONDITIONS (PLEASE LIST):

PREVIOUS SURGICAL PROCEDURES (If you need more room please use reverse of this page):
EXAMPLES: Gallbladder removed, Knee/ Foot/Ankle/ Back/Neck surgery, C-Section, Appendectomy, Hernia etc.

PROCEDURE	DATE

FOOD ALLERGIES AND INTOLERANCES/EATING HABITS HISTORY

FOOD ALLERGIES (PLEASE LIST) (ex. Shellfish, strawberries, nuts, eggs, soy, etc.):

REACTION (check all that apply):

☐ **HIVES** ☐ **SWELLING OF TONGUE** ☐ **TROUBLE BREATHING**

FOOD INTOLERANCES (check all that apply):

☐ **LACTOSE (milk/ dairy)** ☐ **SPICEY** ☐ **ACIDIC** ☐ **CAFFEINE**

☐ **SUGAR SUBSTITUTES** ☐ **MSG** ☐ **GLUTEN**

OTHER:

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, or other)?

YES NO

If YES, please describe:

If you follow a special diet/nutritional program check all that apply:

☐ Low Fat ☐ Low Carb ☐ Lacto Ovo Vegetarian ☐ No Wheat ☐ Weight gain ☐ Other

☐ No Gluten ☐ Vegetarian ☐ Pescetarian ☐ High Protein ☐ Low Sodium

☐ No Dairy ☐ Vegan ☐ Weight loss ☐ Diabetic ☐ Low Sugar

Which meals do you eat regularly, check all that apply:

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks (time _____)

The nutrition/eating habits that are most challenging for me are:

The nutrition/eating habits that I am most pleased with are:

DIGESTIVE HISTORY

How often do you take a bowel movement?

Do you take laxatives? YES NO

If yes, please list type/brand and how often:

Please describe your typical bowel movement (circle one): Hard Soft Loose

Please indicate how often you experience the following symptoms (circle one:

Heartburn	Often	Sometimes	Rarely	Never
Gas	Often	Sometimes	Rarely	Never
Bloating	Often	Sometimes	Rarely	Never
Stomach Pain	Often	Sometimes	Rarely	Never
Nausea/ Vomiting	Often	Sometimes	Rarely	Never
Diarrhea	Often	Sometimes	Rarely	Never
Constipation	Often	Sometimes	Rarely	Never

Have you had any history with eating disorders? (Ex. Binge eating and then vomiting, Binge eating compulsively large quantities of food without vomiting, Waking up and eating late at night, or not eating or eating very little for long periods of time)?

☐ YES ☐ NO

If yes,

Type of disorder:

Age when disorder first occurred/ year:

Duration:

Circumstances that contributed to the issue:

PLEASE LIST CURRENT MEDICATIONS	
MEDICATION	**DOSAGE**

Current Vitamins/ Minerals	Brand	Dosage	Dietary Supplements	☑
Calcium			Fiber	
Vitamin A			Garlic pills	
Vitamin B6			OMEGA 3/6/9	
Vitamin B12			Fish Oil	
Vitamin C			Flaxseed Oil	
Vitamin D			DHEA	
Vitamin E			Glucosamine	
Iron			Chondroitin	
			Black Kohash	
			Premerin	
OTHER:			OTHER:	

PATIENT SPECIAL NEEDS

Do you have any special needs for education materials, or grocery shopping due to (check all that apply): ☐ YES ☐ NO

☐ Low literacy ☐ Poor eyesight ☐ Poor hearing ☐ Does not speak English
☐ Unable to stand/walk/drive vehicle ☐ Unable to cook food due to inability to stand for any length of time
☐ Unable to grocery shop due to inability to drive or stand

If **YES**,
Is there a support person assisting the patient with:

☐ Traveling to appointments ☐ Language Interpretation ☐ Reading food/recipe labels and education materials
☐ Cooking ☐ Grocery Shopping

Fluids & Foods

Beverage Type	Daily Amount	Weekly Amount	If sweetened please list sweetener used:	Serving Size (Ex. 1 cup, 8 ounces, 1 sandwich, etc.)
Coffee (☐ reg ☐ decaf ☐ latte)				
Water				
Tea (☐ reg ☐ decaf)				
Sports/ Performance drinks, TYPE: _____				
Juice (☐ natural ☐ fruit drinks)				
Soda (☐ reg ☐ diet)				
Milk (☐ whole ☐ 2% ☐ 1% ☐ skim)				
Milk Alternative, TYPE: _____				
Alcohol (☐ wine ☐ beer ☐ liquor)				

How often do you eat:	Never	2-3 times/month	1 time/week	2-3 times/week	1 time/day	2-3 times/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria food						
Visit buffets						
Frozen meals						
Home-prepared meals						
Beef						
Poultry						
Pork						
Fish/Seafood						
Lamb						
Deli Meat						
Beans/Legumes						
Green Salads						
Fresh, raw Vegetables						
Fresh/ frozen, fruits						
Canned/packaged vegetables or fruit						
Cooked vegetables						
French fries						
Fried foods						
Crackers, chips, pretzels						
Sweets (cookies, cakes, muffins, pies)						
Whole grains						
Dairy (milk, yogurt, cheese, butter)						
Margarine						

Meal Replacement Products	☑	Brand	How Often?
Liquids			
Shakes			
Bars			
OTHER:			

24 HOUR FOOD RECALL

PLEASE LIST ANY FOOD AND/OR DRINK WITH CALORIES YOU HAVE CONSUMED IN THE LAST 24 HOURS.

Non-Work Day Foods:

Meal/ Snack	Time Eaten	Place (ex. home, cafeteria, name of restaurant)	Description of food item(s) / Meal	Serving Size (Ex. 1 cup, 8 ounces, 1 sandwich, etc.)
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Work Day Foods:

Meal/ Snack	Time Eaten	Place (ex. home, cafeteria, name of restaurant)	Description of food item(s) / Meal	Serving Size (Ex. 1 cup, 8 ounces, 1 sandwich, etc.)
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Who prepares your meals at home?

Who does the majority of your grocery shopping?

Are meals cooked at home low fat? (CHECK ONE) ☐ All the time ☐ Sometimes ☐ Never

What kinds of fats do you use at home for frying and sautéing?
☐ Butter ☐ Margarine ☐ Olive Oil ☐ PAM Spray ☐ Canola Oil ☐ Peanut Oil
☐ Walnut Oil ☐ Avocado Oil ☐ Sesame Oil ☐ Shortening ☐ Lard
Other:

What kinds of spreads do you use on breads, vegetables, etc.?
☐ Butter ☐ Margarine ☐ Olive Oil ☐ Reduced Calorie Margarine ☐ Olive oil butter

Do you ever use sugar substitutes? ☐ YES ☐ NO, If YES,
☐ Splenda ☐ Stevia ☐ Truvia ☐ Monk Fruit ☐ Sweet-N-Low ☐ Equal
Other:

What are the food(s)/ drink(s) that you would you have the hardest time giving up?

Do you wake up in the middle of the night hungry? ☐ YES ☐ NO
If YES, how often?

Do you remember what you eat (CHECK ONE)? ☐ Always ☐ Sometimes ☐ Never

Do you ever binge on food until you are uncomfortable or ill? ☐ YES ☐ NO
If YES, how often?

What kinds of diets and/or diet medications have you attempted in the past to lose weight?

Diet Plan/Medication	Duration

Frequent food cravings:

_____

_____

_____

Food dislikes:

_____

_____

_____

Eating Style: based on how you eat on a regular basis, please check all that apply

□ Fast eater	□ Erratic eater	□ Emotional eater (stressed, bored, sad, etc.)	□ Late-night eater
□ Time constraints	□ Dislike "healthy" food	□ Travel frequently	□ Do not plan meals/menu
□ Rely on convenience items	□ Family member(s) have different tastes	□ Love to eat	□ Eat too much
□ Eat to a point of feeling uncomfortable	□ Eat because I have to	□ Negative relationship with food	□ Struggle with eating issues
□ Confused about food/nutrition	□ "Grab and go" foods	□ Frequently eat out	□ Poor snack choices

PHYSICAL ACTIVITY

Do you exercise now? ☐ YES ☐ NO

Physical Activity: Using the table please describe your physical activity:			
Activity	**Type/Intensity (low-moderate-high)**	**# Days per week**	**Duration (minutes)**
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, TRX, some yoga)			
Other (specify/describe)			

Are there any medical reasons why you cannot or should not exercise? □ YES □ NO

If YES, please describe:

My signature confirms that all of the above information is accurate. I further understand that it is my responsibility to report any changes in my contact information to Nancy Lum, RD, LDN by calling our office on 443-490-1240.

Please bring this questionnaire with you to your initial consultation; there is a $5.00 fee for printing this questionnaire for you. You may also opt to fax to 443-490-5060 or scan and email through our website at www.nutrition5.com prior to your appointment.

X _____ _____

Signature of Patient Date

X _____ _____

Signature of Guardian Date

Materials developed for The GI and Bariatric Nutrition Center, LLC for Nancy Lum, RD, LDN

Financial Policy

Thank you for choosing **The GI and Bariatric Nutrition Center**. We are committed to your weight loss journey being successful. The following is a statement of our **Financial Policy,** which we require that you read and sign prior to your consultation.

Payment Methods Accepted:	**Initial**

- We accept cash, **cashier's** checks, and money orders, MasterCard, Visa and American Express. **We do not accept personal checks.**
- Payment is expected, in full, at the time of service, we do NOT accept post-dated payments. Please contact us to reschedule if you will not have the funds available at the time of your appointment. We reserve the right to refuse service, including materials, if payment is not made at the time of service.

Insurance:	**Initial**

- **We do not participate with insurance companies.** We can provide you with an invoice to submit to your insurance company to see if they will reimburse you, we cannot guarantee that our services will be reimbursed.
- We do not accept Medicare assignment and have opted out; therefore our services are not reimbursable through Medicare. **Please do not submit invoices to Medicare.**

Missed Appointments: Should you need to reschedule your appointment please contact our office directly on **443-490-1240. (Business hours are defined M-Th 9-4PM, except holidays).**	**Initial**

- Appointments missed or cancelled with less than **36 business hours**' notice may be subject to a $45.00 missed appointment fee. Business days/hours are defined as: M-Th 9am to 4pm, we are closed major holidays, and weekends.
- Weight loss documentation missed appointment fees are $20.00.
- If a check is returned unpaid, there will be a $50.00 Insufficient Funds Fee (NSF) charge and personal checks will no longer be accepted as a method of payment. **As of 9/1/2014 we no longer accept personal checks as a method of payment.**

Late Payment Fees:	**Initial**

- A late payment billing charge of 5.00% will be applied to any account which has an original balance ≥ 30 days past due. Each additional month your balance is outstanding, your balance due will accrue interest at the monthly rate of 1.5% or the highest rate allowable by law, whichever is less.
- Accounts >60 days past due will be sent for legal action/ collections, you will be responsible for all costs and fees associated with this process, including court costs and attorneys' fees incurred, regardless of whether a legal proceeding is initiated.
- In the event that either you or we initiate a legal proceeding regarding the terms of this Financial Policy or any other matter related the services we shall be providing to you, the prevailing party in such legal proceeding shall be entitled to collect from the non-prevailing party its court costs and reasonable attorneys' fees.

Services/ Time Limitations:	**Initial**

- If you have enrolled in one of our programs previously and dropped out, or neglected to complete all the services included, within **12 months** from your initial date of service, you will be required to re-enroll in the program and pay the current fee for services.
- If you have completed services, you may re-attend CLASSES (3.5 hour nutrition class, 3 hour Pre-Op class or 3 hour Transition Class) for no additional charge, other than the current fee to provide updated folder/ materials, up to **6 months** from your original date of service. After 6 months from your date of service you will be required to pay the current a la carte fee for the class you wish to re-attend.

I, the undersigned patient, *assume financial responsibility* as stated above and responsibility for all charges and fees if my account becomes past due. I have read, understand, and agree to this Financial Policy. I also understand that required services may be delayed and clearance for surgery withheld until my balance to this office has been paid in full. Fees are subject to change without notice.

X _____ _____

Signature of Patient Date

PATIENT AGREEMENT REGARDING EDUCATIONAL MATERIALS

Pertaining to "The GI & Bariatric Nutrition Center, LLC"

Intellectual, Copyright© and Proprietary Materials

By signing this agreement I, _____, agree that I will not reproduce, disseminate, sell or distribute any materials I am provided with by "The GI and Bariatric Nutrition Center, LLC" (GIBNC). Materials are confidential and contain proprietary information and intellectual property of GIBNC. Neither these materials nor any of the information contained herein may be reproduced or disclosed under any circumstances. Materials include, but are not limited to, our: binders, handouts, Back on Track Program, Bariatric Nutrition Education classes, Pre-Op Classes, Weight-Loss Documentation classes and our Transition Class. As a patient of GIBNC your medical history is established with us and you are under GIBNCs care. Individuals who have not been medically assessed by our staff have not been established as patients, therefore, providing materials to them may can result in serious medical and nutritional complications if not under the specific care of GIBNC. These materials are copyright© protected and proprietary intellectual property of GIBNC. Violation of this agreement may lead to legal prosecution and/or termination of care by GIBNC. Please note this document will become part of your permanent medical chart with our office.

I understand that I am provided with a binder of materials for the 3.5HR bariatric nutrition education class. This is built into the fee for the program. If you should need a replacement the fee is $25.00.

I understand that materials for the 3HR Pre-Op class and 2.5HR Post-Op Transition class are emailed to me no less than 1-2 business days prior to the date I am scheduled. Should you not have email or not have a printer please notify our office. We do not provide hardcopies of these materials, it is a way for us to keep our costs down. Should you request a hardcopy there is a fee of $20.00 per class for the cost of the materials.

_____

(PRINT NAME)

X _____ _____

Signature of Patient Date

HIPAA
Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow The GI and Bariatric Nutrition Center, LLC office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patients written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. Any blood work needed, to prevent delays in surgery, is the patient's responsibility to have the surgeon or primary doctor order, as we do not have the ability to order blood work. These results can take up to 3 weeks to receive. A copy of the lab request form to take to your ordering physician, needed once a year for bariatric clients as per ASMBS guidelines, is located for download off of the www.Nutrition5.com website. The patient can then fax the results to us at 443-490-5060, email to us via www.Nutrition5.com, or bring to their scheduled appointment. Labs are not automatically sent to our office from the ordering physician, it is the patient's responsibility to send a copy to our office. We can also not request copies be sent to us from your physician, this must be done by the patient. It is the patient's responsibility to contact our office to make an appointment to review these labs and receive deficiency repletion information. All follow up appointments have a co-pay for service.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Clinical Dietitian has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

X _____ _____

Signature of Patient Date

Authorization to Release and Discuss Medical Records

Protected health information (PHI) is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual.

I understand under **the Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information.

Patient Name: _____ DOB: _____

Address: _____ City, State, and Zip: _____

Home Phone: _____ Cell: _____ Work: _____

I, _____, give permission to release and discuss my medical records to
(Patient full name - printed)
the below listed custodians of records being requested, to discuss and/or disclose the following protected health information from:

Nancy Lum, RD, LDN; Owner of The GI and Bariatric Nutrition Center, LLC. (GIBNC)
700 Geipe Rd., Ste. 274
Catonsville, MD 21228
Voicemail: 443-490-1240
Fax: 443-490-5060
www.nutrition5.com

(Please list ALL doctors / family members you wish to have access to your medical records with us):

1.
2.
3.
4.

This protected health information is being used or disclosed for the following purposes:

- ✓ Coordination and of patients care with Nancy Lum, RD, LDN.

Information to be disclosed (check all that apply):

Information related to alcohol/drug treatment, abortion, venereal disease, and/or AIDS cannot be disclosed without written consent of the patient/beneficiary. In some instances, information related to mental health and pregnancy/birth control may also require written consent of the patient/beneficiary.)

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Diagnostic Records (including Laboratory/pathology records)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, reproductive health, cancer diagnosis, drug/alcohol abuse, behavioral health service/psychiatric care or sexually transmitted disease (STDS), you are hereby authorizing disclosure of this information unless you exclude below.*

I do NOT agree to have my medical records related to the following treatment(s) checked below, *if nothing is checked these records may be released to Nancy Lum:*

☐ Do not share my - Reproductive health records (ex. Pregnancy, infertility, Postpartum Care, etc.)

☐ Do not share my - HIV/AIDS & STDS Records

☐ Do not share my - Mental Health Records (Nature of Information, as limited as possible: _____)

☐ Do not share my - Alcohol & Drug Abuse Records (Nature of Information, as limited as possible: _____)

This authorization **shall expire no later than**: ___/___/___ (must be greater than 1 month from today, if left blank this authorization will expire 1 year from date form is signed), and may not be valid for greater than one year from the date of signature for Maryland medical records. PLEASE NOTE: If you are a minor child, the expiration date cannot exceed your eighteenth (18) birth date, at which time a new authorization will need to be completed, if desired.

You may revoke this authorization in writing at any time by sending written notification to:
Nancy Lum, RD, LDN
700 Geipe Rd., Ste. 203/274
Catonsville, MD 21228

By signing below, the beneficiary or the beneficiaries representative agrees to the following statements:

1. I understand that my health care will not be affected if I do not sign this form.
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
3. I understand that I may revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to GIBNCs address above. I understand that the revocation will not apply to information that has already been released in response to the authorization.
4. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations
5. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

Maryland law prohibits any person from re-disclosing medical information without authorization from the patient. This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law.

If you are a parent/Court appointed guardian of a minor child, your signature is required together with that of the minor child. If you are a Court appointed guardian of a disabled adult or an authorized representative acting on behalf of a physician certified incapacitated beneficiary, your signature is required, as the beneficiary authorized representative. A complete copy of any legal documents, and if applicable, a certified physician statement granting you the authority to act on this individuals behalf will need to be attached to the form.

Various states allow a beneficiary, younger than age 18, to seek health care services regarding sensitive diagnosis; such as, Pregnancy and Birth Control, Abortion, AIDS and STDs, Mental Health and Alcohol and Substance Use, without the consent of a parent or Court appointed guardian. Therefore, in order to speak with a parent or guardian about such services, this form must be signed and received from the beneficiary **prior** to any sensitive health information being disclosed.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of Patient/ Beneficiary/ Guardian/ Parent/ Custodian Date

_____ _____

Signature of Minor Child Date

Please KEEP the below pages for your records.

✓ **CHECKLIST of what to bring to your initial consultation or first date of service with Nancy Lum:**

☐ **COMPLETED and signed new patient/ patient update questionnaire.**
It is important that the questionnaire and attached forms are completed BEFORE your appointment.*
Printing for you at your consultation will result in a $5.00 fee due at the time of your appointment.

☐ **SIGNED forms:**

- ✓ **Financial Policy – read and sign. Includes information on our accepted methods of payment, late fees, cancellation policy, etc.**
- ✓ **Authorization to Release Medical records – read, complete and sign. (Ex. who you would like to authorize access to your medical records – including your surgeon, primary doctor, specialist, family, significant others, etc.)**
- ✓ **HIPAA form – read and sign**
- ✓ **Patient Agreement regarding education materials – read and sign**

You must read and sign these forms PRIOR to your appointment.

☐ **Fee for your services. See financial policy for accepted methods of payment. We do not accept personal checks. We reserve the right to refuse service if full payment is not made. Please be prepared to pay for services at the beginning of your appointment.**

☐ **If this is a follow-up appointment please remember to bring your labs with you or fax no less than 2 business days prior to your appointment to: 443-490-5060**

***Why must I have the forms and questionnaire completed before my appointment?**

Nancy needs the full 1-hour consultation to establish you as a patient, review your questionnaire, get your medical history, calculate your protein needs and assess you as a surgical candidate. Not having forms ready before your appointment will reduce the amount of time she is able to individually assess you as a surgery candidate. The completed paperwork must also be sent out for data entry.

PATIENT RESPONSIBILITIES:

1. Please write down ALL appointments/ classes and keep handy. **We do NOT have the ability to do appointment reminders for classes and weight loss documentation appointments due to patient volume.** It is your responsibility to keep track of your appointments and classes.
2. Please come to all appointments on time, as scheduled. If you are going to be late for an appointment or class you will be required to reschedule, please call 443-490-1240. Tardiness and leaving early is disruptive to the rest of the class participants**. We cannot sign off that you have attended a class if you have not attended them in their entirety. Tardiness or leaving early will result in your having to re-attend/reschedule.**
3. Please be sure to read our Financial Policy for information regarding fees for missed and cancelled appointments. As well as other important information regarding fees and payments.
4. Children are not permitted in classes. If you do not have proper daycare please call our office on 443-490-1240 to reschedule.
5. Any blood work needed, to prevent delays in surgery, is the patient's responsibility to have the surgeon or primary doctor order, as we do not have the ability to order blood work. These results can take up to 3 weeks to receive. A copy of the lab request form to take to your ordering physician, needed once a year for bariatric clients as per ASMBS guidelines, is located for download off of the www.Nutrition5.com website. The patient can then fax the results to us at 443-490-5060, email to us via www.Nutrition5.com, or bring to their scheduled appointment. Labs are not automatically sent to our office from the ordering physician, it is the patient's responsibility to send a copy to our office. We can also not request copies be sent to us from your physician, this must be done by the patient. It is the patient's responsibility to contact our office to make an appointment to review these labs and receive deficiency repletion information. All follow up appointments have a co-pay for service.

IMPORTANT REMINDERS:

Appointment availability (you must be scheduled ahead of time to attend classes, call 443-490-1240):

- Nancy is in clinic Monday & Wednesday at our office in Catonsville and Thursday in Westminster or Catonsville as needed, her hours for individual appointments are from 9AM-4PM. Please call 443-490-1240 for scheduling.

Please try to keep your appointments as scheduled, as we cannot always guarantee we will be able to reschedule you later in the same calendar month. Rescheduling is based strictly on appointment availability. Should you need to reschedule any appointments please contact us at: 443-490-1240.

Missed appointments or appointments cancelled with LESS THAN 36 *business* hours' notice are subject to a missed appointment fee, see financial policy for details. Not cancelling appointments with adequate time for us to reschedule someone in your place delays someone else's ability to come see us and their process of beginning the steps necessary to get their surgery approved. Business hours are considered non-holidays, M-F from 9am-5pm.