Healthwise studio
mindfulness & yoga psychology

NOTICE OF PRIVACY PRACTICES

All patient information is handled under the HIPAA Privacy Act
CONFIDENTIAL

The privacy of your medical information, as described in the HIPAA Privacy Act, is important. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other health care providers to assist them in treating you.

Kimberly Plessel, LLC
Healthwise Studio
11110 86 Ave N
Maple Grove, MN 55369

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signed _____ **Date** _____

NOTICE

State law allows any person to provide nutritional advice or give advice concerning proper nutrition – which is the giving of advice as to the role of food and food ingredient, including dietary supplements. This state law does NOT confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury, or physical or mental condition and specifically does not authorize any person other than one who is licensed health practitioner to state that any product might cure any disease, disorder, or condition.

Signed _____ **Date** _____

INFORMED CONSENT / RELEASE

I am solely responsible for the decision to see Kimberly Plessel, LLC for Medical Nutritional Therapy. I recognize that some recommendations may not prove to be successful. I understand some recommendations may be novel. I agree to participate in an active manner, monitor my progress, and report any concerns to Kimberly Plessel, LLC. I also understand that any significant symptoms should be reported to my physician. It is also recommended that I discuss the use of any nutritional supplements with my physician before implementing. By signing below, I hereby release Kimberly Plessel, LCC from any claims for illness or injury that might occur during or as a result of my participation in nutrition counseling, together with any and all claims, causes of action, costs or expenses of any kind whatsoever arising out of my participation in nutrition counseling.

Signed _____ **Date** _____