

RAW FUNCTIONAL NUTRITION – CLIENT PACKET

Welcome to RAW Functional Nutrition (“RFN”)! We are a nutrition and wellness organization comprised of nutritionists who are licensed by the North Carolina State Board of Dietetics/Nutrition and certified by the Certification Board for Nutrition Specialists. Your physician has referred you to us so that we can help you achieve the highest state of health consistent with your own goals.

Our consultations may include education about the nutritional value of certain foods, such as specific discussion about vitamins, minerals, herbs, amino acids, and fatty acids. We may work with you to develop dietary and lifestyle recommendations, meal plans, and other methods to promote your health. We will also monitor and evaluate your progress over time at our regular meetings, adjusting the plan as needed to help you achieve optimal health.

Importantly: RFN’s nutrition and wellness advice is intended to complement, **but not replace**, your medical provider’s treatment plan. RFN may recommend certain foods, herbs, and vitamins as part of our services to you. However, you should **always follow your medical provider’s guidance** about your intake and lifestyle.

Please review the contents of this Client Packet, which include:

1. Client Rights and Responsibilities Agreement
2. Release of Billing Information and Financial Responsibility Form
3. Communications Preferences Form
4. HIPAA Notice of Privacy Practices

Please sign below to indicate that you have reviewed each of these documents, have had the opportunity to ask questions (and have had any questions answered to your satisfaction), and that you agree to the terms and conditions within. We look forward to being a partner in your health and wellness journey.

Client Name: _____

Parent or Legal Guardian Name [if applicable]: _____

Client Signature: _____ [If Client is a Minor, Parent or Legal Guardian Must Sign]

Date: _____

RAW FUNCTIONAL NUTRITION – CLIENT RIGHTS AND RESPONSIBILITIES

The purpose of this document is to establish your rights and responsibilities as an RFN client so that you and your nutritionist can work together effectively, communicate clearly, and create the best possible conditions for achieving your nutrition and wellness goals.

You are responsible for:

1. Fully disclosing all relevant health information to RFN and keeping RFN informed about any material changes to your health information for as long as you receive services from us.
2. Informing RFN if your nutrition and wellness goals change.
3. Attending all scheduled consultations, which means arriving on time and staying for the duration of the consultation.
4. Treating your RNF nutritionist and all RFN staff with respect. Any violent, threatening, or hostile behavior is grounds for dismissal as an RFN client.
5. Timely paying for RFN's services consistent with RFN's Billing Policies and Financial Responsibility Form.

You have the right to:

1. Professional and polite interactions with your nutritionist. If you ever feel you have not been treated in a professional and polite manner, please contact our Owner / Licensed Nutritionist, Maggie King at (910) 226-2129 or maggie@rawfunctionalnutrition.com.
6. Reject any recommendation from your RFN nutritionist. Ultimately, you are in control of your nutrition and wellness decisions. You decide whether to accept the recommendations of your RFN nutritionist and the extent to which you adopt those recommendations into your lifestyle between RFN appointments.
2. End your engagement with RFN at any time. We want to help you improve your nutrition and overall wellness, and if at any point you feel our organization isn't the right fit, we will gladly provide a copy of your records to you or to another provider of your choosing.

Important Notes

1. **RFN's nutritionist are not physicians and therefore cannot diagnose or treat disease, or prescribe medications.** RFN's nutrition and wellness advice is intended to complement, **but not replace**, your medical provider's treatment plan. RFN may recommend certain foods, herbs, and vitamins as part of our services to you. **However, you should always follow your medical provider's guidance about your intake and lifestyle.**
2. Confirmed cases of herb, nutrient, and drug interactions are rare. However, adverse events can occur after using any active substance, including allergic responses. Therefore, it is critical that you disclose to your nutritionist all medications, supplements, and herbs currently in use, any liver or kidney disease (past or present), any allergies, any recreational drug or alcohol use, and whether you are, or could be, pregnant or breastfeeding. All of this can be disclosed in your intake form that is asked to be completed before your first appointment.
3. RFN cannot guarantee that you achieve your stated nutrition and wellness goals within any particular timeframe (or at all). However, the chances of a successful experience increase if you fulfill your responsibilities above.

**RAW FUNCTIONAL NUTRITION –
RELEASE OF BILLING INFORMATION AND FINANCIAL RESPONSIBILITY FORM**

Please carefully review the information below and sign below if you agree. If the client is a minor child, the parent or legal guardian should complete this form.

1. I authorize RAW Functional Nutrition, LLC (“RFN”) to release and disclose any information that is necessary for RFN to process claims, secure payments, or ensure continuity of care for me (or my minor child, as applicable). This information may be shared with my health insurance provider, with healthcare providers involved in my care, or other entities as needed for RFN to ensure payment for services rendered.
2. I agree that I am responsible for payment for services rendered by RFN to me (or to my minor child, as applicable). I am financially responsible for all services and items that are not covered by my insurance company, which includes any co-pays, deductibles, or other cost-sharing charges that may be required under my policy. I authorize RFN to charge my credit card on file for these amounts.
3. I assign my right to payment for all health services covered by my health insurance provider to RFN, including benefits from Medicare, Medicaid, and any other state or federal, government or private insurance providers.
4. I agree to notify RFN immediately if my health insurance coverage terminates or changes. This includes any changes in my eligibility as an NC Medicaid beneficiary (if applicable) and/or any restrictions on the coverage to which I may be subject (regardless of payor).
5. I understand that RFN’s initial consultation fee is \$200 (for a 90-minute session) and that any additional consultations cost \$125 per session (for a 60-minute session). Payment is due at the time services are rendered. Consults that exceed the allotted length of time are billed at \$30 per each additional 15-minute increment. Consultations outside of normally scheduled appointments, for example a stand-alone phone call to address a client question, are billed at \$30 per each 15-minute increment.
6. I understand that I will be charged the full consultation fee if I no call, no show. I will be charged half of the consultation fee for every scheduled session that is not cancelled with 24 hours’ prior notice. Additionally, if I am late to a scheduled session, I understand that my session will end at the scheduled time and that I am responsible for the cost of the full session, notwithstanding the late start.

Client Name: _____

Parent or Legal Guardian Name [if applicable]: _____

Client Signature: _____ [If Client is a Minor, Parent or Legal Guardian Must Sign]

Date: _____

RAW FUNCTIONAL NUTRITION – COMMUNICATION PREFERENCES

Your Communications to RFN

You may contact RFN in the following ways:

Email: info@rawfunctionalnutrition.com

Phone (or text): (910) 266-2129

Fax: (910) 226-0172

In the case of emergency, do NOT use the contact information above – instead, call 911 or visit the nearest hospital or urgent care as appropriate.

RFN’s Communications to You

I request and permit RAW Functional Nutrition (“RFN”) to leave telephone messages that may contain health information about me at the following numbers:

Home Phone	
Work Phone	
Cell Phone	

I request and permit RFN to communicate with me via email, even for messages that may contain health information. RFN can email me at the following address:

Email Address	
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I understand that communications via telephone and email may not be encrypted and therefore there is some level of risk that the information in the telephone message or email could be accessed or read by a third party. I am aware of this risk and still prefer to receive communications via telephone and email.

I authorize RFN to communicate about my care with the following individual(s):

First Name	
Last Name	
Relationship to Client	
Phone Number	

I will notify RNF promptly if my contact information or my contact preferences change.

Client Name: _____

Parent or Legal Guardian Name [if applicable]: _____

Client Signature: _____ [If Client is a Minor, Parent or Legal Guardian Must Sign]

Date: _____

NOTICE OF PRIVACY PRACTICES – RAW FUNCTIONAL NUTRITION

PLEASE REVIEW THIS NOTICE CAREFULLY. THIS NOTICE DESCRIBES:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED.
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION, INCLUDING HOW YOU CAN GET ACCESS TO THIS INFORMATION.
- HOW TO FILE A COMPLAINT ABOUT A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH RAW FUNCTIONAL NUTRITION LLC AT (910) 226-2129 AND info@rawfunctionalnutrition.com IF YOU HAVE ANY QUESTIONS.

GENERAL INFORMATION

All of RAW Functional Nutrition's ("RFN") health information concerning you is subject to the federal HIPAA law ("HIPAA") and, as applicable, to 42 C.F.R. Part 2 ("Part 2"). This Notice addresses the requirements of HIPAA and Part 2 as applicable. This is important because Part 2 provides greater protection in certain situations.

Your health information is generally referred to in this Notice as your "information." This Notice applies to all of the information we have concerning you, including information obtained before the effective date of this Notice and afterwards.

OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Uses & Disclosures for Treatment, Payment, and Health Care Operations.

HIPAA lets us use and disclose your information without your consent for treatment, payment, and health care operations, as follows:

- *Treat you*—We can use your information for providing treatment, medication administration, and other health care services to you and can share your information with other professionals treating you. Example: A doctor treating you for a condition asks us for information related to your health.
- *Bill for your services*—We can use and share your information to bill and get paid by health plans or other parties and to enable other providers to get paid. Example: We give information about you to your health insurance plan and to your representative so they can pay for your services.
- *Run our organization (i.e., for our health care operations)*—We can use and share your information to run our facility, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. We can also share your information with another provider for the provider's own health care operations as long as we both have or had a relationship with you and certain other requirements are met.

To the extent that we have your substance use disorder patient records, subject to Part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Certain Uses and Disclosures Without Your Consent.

HIPAA lets us use and disclose your information without your written authorization in other situations—usually in ways that contribute to the public good. We must meet many legal requirements to do this. This includes:

- *When required by law*—We can share your information if a law requires that we share it. There are various requirements we must meet in these situations.
- *Public health issues*—We can share your information for certain public health reasons such as preventing disease, helping with product recalls, and reporting adverse events related to medications.
- *Victims of abuse, neglect, or domestic violence*—We can disclose information related to suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.
- *Health Oversight*—We can disclose information for the oversight activities of entities that oversee the health system.

- Judicial and Administrative Proceedings—We can use and share your information in judicial and administrative proceedings, including in response to court orders and subpoenas, subject to various limitations.
- Law enforcement purposes—We can use and disclose your information for a law enforcement purpose to a law enforcement official if various requirements are met.
- Coroner, medical examiner, and funeral directors—We can disclose information to a coroner or medical examiner for identifying a deceased person, determining cause of death, or other duties as authorized by law and may disclose information to funeral directors, consistent with applicable law, as necessary for them to perform their duties.
- Organ procurement—We can use or disclose information to organ procurement organizations.
- Do research—We can use or share your information for health research.
- Avert a serious threat to health or safety—We can use or disclose your information if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you, another person, or the public, or is necessary for law enforcement authorities to identify or apprehend certain individuals, if various requirements are met.
- Specialized government functions—We can use and disclose your information for certain military, veteran, and national security and intelligence purposes, for protective services for the President and certain others, for correctional institution-related purposes, and for certain reports to the National Instant Criminal Background Check System, under certain limited circumstances.
- Workers' compensation—We can disclose your information as necessary to comply with laws relating to workers' compensation or similar programs, as long as such disclosure is authorized by law.
- Work with business associates—We can share information with our business associates.
- Your personal representative—We can share your information in certain situations with your personal representative if you have one.
- Incidental uses or disclosures—We can make uses and disclosures that are merely incidental to otherwise permitted or required disclosures, as long as we otherwise fully comply with HIPAA.
- For our facility directory—We can share certain limited information through our facility directory in certain emergency situations.
- Your family and friends—We can share with your family, friend, or other person identified by you certain limited information that is relevant to the person's involvement with your care or payment for care if we determine the disclosure is in your best interest, or in the event of your death.
- To notify family and friends—We can use and share limited information to notify your family, personal representative, or other person responsible for your care about your location, general condition, or death if we determine the disclosure is in your best interest, or in the event of your death, including sharing such information with entities assisting with disaster relief.
- Limited Data Set—We can create, use, and disclose your information if certain identifiers are removed (a "limited data set"). The limited data set may be used only for research, public health, or health care operations, and a special, HIPAA-compliant agreement, must be entered into between us and any of the data recipients.
- Fundraising—We can contact you to raise funds for ourselves, and you have the right to opt out of receiving such communications.
- To HHS—We must disclose your information if the Secretary of HHS requires it for investigating or determining our compliance with HIPAA.
- De-Identified information—We can remove all identifiers from your health information so that the information no longer identifies you. Once the information is de-identified, it is no longer subject to HIPAA.

- Your estate administrator—If you die, we can disclose your information to an executor, administrator, or other person with authority to act for or on behalf of you or your estate.
- Certain emergencies—If we agree with you to limit our uses or disclosures of your information for treatment, payment, health care operations, or for contacting individuals involved in your care or payment for care, we may use and disclose the information despite the restriction *if* you need emergency treatment and the information is needed to provide that treatment.

Uses and Disclosures that Require Your Written Authorization.

HIPAA requires that we obtain your written authorization before we use or disclose psychotherapy notes (except in certain specific situations), use or disclose your information for marketing (except in certain specific situations), or sell your information.

You may revoke a written consent for the use or disclosure of your information at any time, but the revocation must be written and the revocation is not effective to the extent that we have already acted in reliance on the consent.

We will not use or disclose your information in any way that is not described in this Notice without first getting your written consent.

Redisclosures.

Once we disclose your information to a party as permitted by HIPAA or Part 2, the information might be redisclosed and no longer protected, depending on the circumstances.

Fundraising.

HIPAA allows us to contact you to raise funds for us, and you have a right to opt out of receiving such communications. If we have your substance use disorder patient records, subject to Part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

YOUR RIGHTS

Request Restrictions. You have the right to request restrictions of uses and disclosures of your information for treatment, payment, or health care operations and to individuals involved in or responsible for your care (such as certain family and friends). We are not required to agree to a requested restriction, except if you request that we restrict disclosures to a health plan for payment or health care operations, the disclosure is not otherwise legally required, and information pertains only to services or items for which you have paid us in full. If we agree to a restriction, we are still permitted to make certain disclosures needed for your emergency treatment, and certain other limited disclosures.

Confidential Communications. You have the right to request communication of your information by alternative means or at alternative locations. We must accommodate reasonable requests.

Access to Information. You have the right to access your information to inspect it and to receive an electronic or paper copy of your information. Ask us how to do this. We may charge a reasonable, cost-based fee for the copies, mailing, or other supplies associated with your request. We may deny your request under certain circumstances.

Corrections to Information. You have the right to ask us to correct (or amend) your medical record if you think it is incorrect or incomplete. Ask us how to do this. We have the right to deny the request, and we will explain any denial.

List of Disclosures. Under HIPAA, you have the right to a list (or accounting) of our disclosures of your information in the past six years, except for certain types of disclosures including those for treatment, payment and health care operations, and those you authorized us to make. The accounting will tell the times we have shared your information, who we shared it with, and why.

Copy of this Notice. You have the right to obtain a paper or electronic copy of this Notice upon request.

Discuss this Notice. You have the right to discuss this Notice with the person listed below in the “Contact Us” section.

Fundraising. As noted above, you have the right to elect not to receive our fundraising communications.

OUR DUTIES

Maintain Privacy. We are required by law to maintain the privacy of your information, to provide you with Notice of our legal duties and privacy practices with respect to the information (which we are doing through this Notice), and to notify affected individuals if there is a breach of unsecured information.

Abide by Notice. We are required to abide by the terms of this Notice currently in effect.

Change the Notice. We can change the terms of this Notice, and the changes will apply to all information we have about you, including PHI received before the changes. Any revised Notice will be available upon request, posted prominently in our offices where services are furnished, and on our website.

Other Laws. If any North Carolina law, including the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 (N.C. Gen. Stat. § 122C-1, et seq.), or other law imposes greater restrictions on our uses and disclosures of your information than those imposed by HIPAA and Part 2 and reflected in this Notice, we will abide by the more restrictive laws.

CONCERNS, COMPLAINTS & REQUESTS

You may complain to us if you feel your privacy rights have been violated. You may also contact us with questions and for additional information about this Notice. To do so, please contact the person listed below in “Contact Us.”

You may also file a complaint with U.S. Department of Health and Human Services Office for Civil Rights (“HHS”) by mail, fax, e-mail, or via the OCR Complaint Portal if you feel your privacy rights have been violated. HHS’s current website concerning complaints is located at <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.

We will not retaliate against you for filing a complaint.

CONTACT US.

To contact us about matters related to this Notice and your rights, please contact RAW Functional Nutrition LLC, (910) 226-2129, info@rawfunctionalnutrition.com.

EFFECTIVE DATE OF THIS NOTICE

This Notice of Privacy Practices is effective as of 05/07/2026.



RAW Functional Nutrition Adult Intake Form

Complete this form to the best of your knowledge and as detailed as possible. This should take about 40 minutes to complete but it helps me significantly! Thank you :).

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal Code

Home Phone

Mobile Phone

Email Address

Date of Birth

Gender

Relationship Status

Occupation

Hours Per Week

Referred By

Health Insurance

Policy Holder First Name Last Name

Date of Birth Phone

Gender

Street Unit

City State/Province Postal Code

Insurance Company Payer Id Coverage Type

Member Id Plan Id Group Id

Copay Deductible

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Medications / Supplements

Have you ever taken antibiotics? Yes No

Have you ever taken birth control? Yes No

Have you ever been on hormone replacement therapy? Yes No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

Digestive

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement?

Yes

No

Are your bowels loose?

Yes

No

Do you take laxatives?

Yes

No

Allergies

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods?

Yes

No

Diet

How much water do you drink daily?

Do you consume coffee? Yes No

Do you consume tea? Yes No

Do you consume alcohol? Yes No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Where do you grocery shop?

Do you experience any symptoms after meals?

Describe your relationship with food

Please be specific

Anthropometrics

Physical Assessment

Height	
Weight	
Ideal Weight	
Highest Adult Weight / Year	
Lowest Adult Weight / Year	

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? Do you wake frequently during the night?

Do you wake feeling rested? Yes No

How often do you exercise?

What types of exercise do you do?

What do you do to have fun?

Do you have any pets? Yes No

What level of stress are you currently experiencing?

1 2 3 4 5 6 7 8 9 10

1 = Not much stress, 10 = An immense amount stress

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up?

City

Country

City or country?

What type of environment do you/ have you worked in?

Do you smoke cigarettes or vape?

Yes

No

Have you had any dental work done?

Do you have fillings (metal), root canals, crowns, etc?

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

1 2 3 4 5 6 7 8 9 10

1 = Lowest, 10 = Highest



RAW Functional Nutrition

My Symptom Questionnaire (MySQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0 = Never

1 = Rarely, Effect not severe

2 = Occasionally, Effect not severe

3 = Occasionally, Effect severe

4 = Frequently, Effect not severe

5 = Frequently, Effect severe

Head

Headaches

Faintness

Dizziness

Total

Nose

Stuffy nose

Sinus problems

Hay fever

Sneezing attacks

Excessive mucus formation

Loss sense of smell

Total

Nails

Spoon shaped Brittle, cracking

Discolored White spots

Lines/Stripes

Total

Hair

Hair thinning Hair loss

Loss of outer eyebrow hair Premature greying

Easy hair pluckability

Total

Skin

Acne Hives, rashes

Dry skin Bumps on back of arms

Flushing Excessive sweating

Total

Immune

Colds Flu

Chronic infections

Total

Genitourinary

Frequent or urgent urination

Itching

Discharge

Incontinence

Total

Eyes

Watery/itchy eyes

Yellowing eyes

Swollen, reddened, sticky eyelids

Bags, dark circles

Night vision problems

Blurred vision

Loss peripheral vision

Total

Mouth/Throat

Chronic coughing

Gagging frequently, throat clearing

Sore throat

Hoarseness

Swollen/discolored tongue

Burning tongue

Coating on tongue

Chewing problems

Canker Sores

Fever blisters

Cracks corner of mouth

Total

Heart

Irregular/skipped beats

Rapid/ pounding beats

Chest Pain

Total

Lungs

Chest Congestion

Asthma or bronchitis

Shortness of breath

Difficulty Breathing

Total

Energy/Sleep

Fatigue

Lethargy

Hyperactivity

Insomnia

Sleep disruptions

Total

Neurological

Poor memory

Confusion

Poor concentration/"brain fog"

Poor physical coordination

Loss of balance

Tingling in hands or feet

Stuttering or stammering

Slurred speech

Total

Ears

Itchy Ears

Ear aches, ear infections

Drainage from ear

ringing

Hearing loss

Total

Digestive Tract/Gastrointestinal (GI)

Nausea	Vomiting
Diarrhea	Constipation
Alternating diarrhea & constipation	Bloating
Belching	Gas/flatulence
Heartburn	Upper GI pain
Lower abdominal pain	
<i>Total</i>	

Joints/Muscle/Bone

Pain or aches in joints	Arthritis
Stiffness/limited movement	Pain or aches in muscles
Feeling of weakness or loss of strength	Restless legs
Bone pain	Broken bones
<i>Total</i>	

Weight

Underweight	Overweight
Obese	Weight loss (>5-10 lbs)
Weight gain (>5-10 lbs)	Fluid retention
<i>Total</i>	



RAW Functional Nutrition

3-Day Food Journal

Please list all food and beverages consumed, including water, for each day. Do not change your eating behavior; the purpose of this food record is to analyze your current eating habits. Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc. Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc. If possible, journal for 2 work days and 1 off day.

Day 1

Day 1: Food & Drinks

	Time	Beverages	Food
Breakfast			
Lunch			
Dinner			
Snacks			

Day 2

Day 2: Food & Drinks

	Time	Beverages	Food
Breakfast			
Lunch			
Dinner			
Snacks			

Day 3

Day 3: Food & Drinks

	Time	Beverages	Food
Breakfast			
Lunch			
Dinner			
Snacks			